Authorization to Disclose Health Information

PERSONAL MD®

Patient Name (Print): Date of Birth:

Release Protected Health Information To:

Send Records To:

Address: City: State: Zip:

Phone: Fax:

Release Protected Health Information From:

Personal MD Family Healthcare, P.A.
2770 Virginia Parkway, Suite 301, McKinney, Texas 75071
Phone: 214-726-0755 **Fax: 214-585-0449**

What Information Can Be Disclosed:

___ **All Health Information** ___ EKG/Cardiology Reports ___ Past/Present Medication
___ Immunization History ___ Radiology reports ___ Operation Reports
___ Laboratory Results ___ Pathology Results ___ Other:_____
___ Records from the following dates: _____ to _____

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes) _____ Drug, Alcohol, or Substance Abuse Records
_____ Genetic Information (including Genetic Test Results) _____ HIV/AIDS Test Results/Treatment

Reason For Disclosure:

___ Changing Physicians ___ Billing or Claims ___ Insurance Evaluation
___ Legal Purpose ___ Employment ___ School
___ Personal Use ___ Other: _____

Signature Authorization:

Effective Time Period: This authorization is valid until the earlier of the occurrence of the death of the individual: the individual reaching the age of majority; or permission is withdrawn; or the following specific date: _____.

Right To Revoke:I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named "Release Protected Health Information To." I understand that prior actions taken in release of this authorization by entities that had permission to access my health information will not be affected.

Signature Authorization: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that is permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code 181.154c and/or 45 c.F.R. 164.502a1.

SIGNATURE _____ DATE: _____
Signature of Individual or Individual's Legally Authorized Representative

If you are a representative, specify your relation to the individual: ____ Parent ____ Guardian ____ Other _____

Signature of Minor: _____ Needed for the release of information related to reproductive care, sexually transmitted diseases, drug, alcohol, or substance abuse, and mental health treatment (See Tex. Fam. Code 32.003)