

Authorization to Disclose Health Information



Release Protected Health Information To:

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

Release Protected Health Information From:

Patient Name: _____ **Date of Birth:** _____

Owner of Records: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

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
 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earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date: _____.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)