

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the following to disclose my individually identifiable health information as described below:

Olympus Family Medicine

4461 Coit Road, Suite 307

Frisco, Texas 75035

Phone: 972-377-0322 **Fax:** 972-502-9515

This information may include, but is not limited to, material concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

Print Patient Full Name

Date of Birth

Purpose of Information Release: _____

Description of Information to be Released: (check all that apply)

All Available Medical Records (Including, but not limited to all below listed options.)

Please only release the following specified information:

Hospital Admission Records / Operative Reports / Billing Records / Discharge Records

Radiology Reports & Films

Consultation Reports

Laboratory / Pathology Reports

Emergency Room Records

Physician's Orders

Physician's Notes & Progress Notes

History & Physical

Nurse's Notes

Specific Dates: _____

The health information described herein shall be released to:

Doctor/Hospital Name: _____

Street Address

Suite Number

Phone # _____

Fax # _____

City

State

Zip

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I further understand that I may revoke this authorization at any time by notifying this office in writing. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of Patient or Patient's Representative

Date

Printed Name of Patient's Representative

Relationship to Patient

OR _____
Legal Authority (attach supporting documentation)