AUTHORIZATION FOR RELEASE OF RECORDS

I hereby authorize:

_____
(Entity/Person from Whom Records are Requested)

_____
(Full and Complete Address)

_____
(Phone Number and Fax Number if available)

to disclose my individually identifiable health information as described below, which may include information 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 Name | Date of Birth | Social Security Number

Date(s) of service (if known):_____

Description of information to be released: (check all that apply)

____ Hospital admission records / Operative records / Billing records / Discharge records

____ Radiology reports & films ____ Consultation reports ____ Laboratory reports

____ Emergency Room records ____ Physician's orders ____ Physician's notes & Progress notes

____ History & Physical ____ Nurse's notes ____ Other: _____

Purpose of release of information: Continuity of care for primary care physician

The health information described herein shall be released to:

____ Hospital **__X__ Physician** ____ Insurance Company ____ Attorney ____ Patient ____ Other

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Frisco, Texas 75035
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I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until_____
(Expiration event/date)

I further understand that I may revoke this authorization at any time by notifying _____in
(Person/Entity from Whom Records are Requested)

writing at _____. I also understand that the written revocation must
(Address)

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)