AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

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

Doctor/Hospital Name: ____

____
Street Address Suite Number

____
City State Zip

○ **Phone #** ______________________________

○ **Fax #** ______________________________

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: Continuity of Care for Primary Care Physician Office

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:

Olympus Family Medicine

4461 Coit Road, Suite 307

Frisco, Texas 75035

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

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)