AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____

Date of Birth _____ Social Security # _____

I authorize the following individual or organization to disclose the above named individual's health

information:_____ Address: _____

PHONE:_____ FAX:_____
This information may be disclosed TO and used by the following individual or organization:

MIKEAL LOVE, M.D., PA
Address: **900 EAST 30TH ST., #211, AUSTIN TX 78705**
PHONE**: 512-476-9699 /** FAX**: 512-476-6168**
For the purpose of: _____
Please release the following:

___Office Visit Records
___Ultrasound Reports: (specify dates)_____
___Lab Results
___Hospital Records: (specify dates)_____

I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS, or HIV. It may also include information about behavioral or mental services, and treatment for alcohol or drug abuse.

____Yes, I consent to the release of this information ____ No, I do not consent to the release of this information

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, the authorization will expire on the following date, event, or condition: _____.
If I fail to specify an expiration date, event or condition, this authorization **will expire in six months**.

I understand that Mikeal Love, M.D., PA follows the Texas Medical Board regulations to approve an initial fee of $25 for the first 20 pages of a record, $.50/page, postage and the cost of labor to copy the records. I understand that the charge for this service is payable in advance. After payment is received, I can expect the requested copies by the end of 15 **business** days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I can contact Amy Love, HIPAA Privacy Officer, at the office of Mikeal Love, M.D., PA.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____

Relationship to Patient (if Legal Representative) Witness

Date request completed:_____ #of pgs copied:_____ Charges:_____

Initials:_____