Surgical Consultants of Dallas, L.L.C

HIPAA Compliant Authorization for Release of Medical Information

Date_____

Patient Name: _____DOB:_____

Last 4 digits of SS#_____ Surgeon Name_____

I authorize and request the disclosure of the following protected health information for the purpose of review and evaluation in connection with my surgery case. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following (please circle):

Office Notes	Hospital Records	Operative Reports
Lab Results	Pathology Reports	Imaging Studies

Other: _____

This protected health information is disclosed for the following purposes:

This authorization is given in compliance with the federal consent requirements for the release of alcohol and substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically waived.

I authorize Surgical Consultants of Dallas, L.L.C to receive the above records from: (Include Name, Address and Fax Number)

I understand the following:

a. I have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

This authorization shall be in force and effect until two years from the date of execution at which time this authorization expires.

_____ _____

Signature of Patient or Authorized Representative Name of Patient or Authorized Representative

Date: _____

Surgical Consultants of Dallas, LLC
7777 Forest Lane Suite A-331
Dallas, TX 75230
(972) 566-7860
www.surgicalconsultantsofdallas.com