AUTHORIZATION OF USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

A-Z Internal Medicine
4109 Brown Trail Suite 101
Colleyville, TX 76034
Ph (817) 514-8600   Fax (817) 514-8601

This authorizes Person(s)/Entity ____

Address: ____

City, State, Zip: ____

Phone: ____________________________   Fax: ______________________________

to provide a copy, summary or narrative of my medical records as indicated below by checkmark to

Person(s)/Entity ____

Address: ____

City, State, Zip: ____

Phone: ____________________________   Fax: ______________________________

<u>INFORMATION TO BE RELEASED</u>

_ Dates of Service ______________   _ Consultation Reports   _ Operative Reports

_ Fact Sheet   _ Lab/Pathology Reports   _ X-Ray Reports/Images

_ Immunizations   _ All Records   _ ____________________

<u>REASON FOR RELEASE OF RECORDS</u>: ____________________________________

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but it not limited to: history, diagnosis, and/or treatment of tobacco, drug, or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization. I understand I may be charged a retrieval/processing fee for copies of my medical records according to the Texas State Board of Medical Examiners.

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows:

Date: ____________

Patient Name:____________________________ Signature:______________________________

(Patient, Guardian, or Legal Representative)

Social Security #: __________________________ Date of Birth: ___________________________