Authorization to Release Medical Information

Patient Name: ______________________________ Date: ____________________

Date of Birth: __________________ Phone #: __________________

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: ______________________________ Facility Phone: ____________

Facility Address: ____ Facility Fax: _____________

City State Zip

Reason for Request: ____________________________ Date(s) of Treatment: __________________

Information to be Released or Accessed:

- ▢ All Records
- ▢ Clinic Notes
- ▢ Procedure Notes
- ▢ Lab/Pathology Reports
- ▢ Behavioral Health
- ▢ Consultation Reports
- ▢ EKG Reports
- ▢ Radiology Reports
- ▢ Radiology Images
- ▢ Immunizations
- ▢ Medication/Prescription List
- ▢ Problem List
- ▢ Other_______________

This information may be disclosed and used by the following individual or organization:

Release To: ________________________________ Facility Phone: ____________

Facility Address: ____ Facility Fax: _____________

City State Zip

Method of Delivery:

- ▢ Fax #: __________________
- ▢ Mail to address listed above or other: ____

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 is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that the 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 in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee and for companies of my medical records according to Texas Hospital Licensing law.

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: ______________________________.

X______________________________
Printed Name of Patient

X______________________
Date

X______________________________
Signature of Patient or Guardian

X______________________
Relationship to Patient

Ken Park MD ◆ 8994 Tour Dr. Suite 210, McKinney, TX ◆ Phone: (972) 449 - 5900 ◆ Fax: (972) 449 - 7100