AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

URGENCY OF REQUEST

_____STAT _____ASAP _____TODAY ______DATE _____WHEN AVAILABLE

To: Physician or Clinic/Facility Name and Address

____ Phone ________________

____Fax ____________________

From: Heritage Family Medicine & Aesthetics
4214 Gateway Drive Suite 100
Colleyville, Texas 76034

Phone: 817-354-7999
Fax: 817-571-2140

Patient's Name ________________________________Social Security # ________________

Date of Birth _________________________________Date of Service __________________

RECORDS NEEDED

______ER notes and diagnostic reports _____All in-patient dictation and diagnostic reports .
______History and Physical _____Discharge Summary _____Operative report _____Consultation
______Ekg _____Labs _____Radiology _____Echo
______Progress notes _____PFT _____Holter Monitor _____Orders
______Medication Records
Other ____

REASON FOR RELEASE

_____Continuing Care _____Referral _____Payment _____Legal _____Patient's request

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 redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: History, diagnoses, and/or treatment of 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 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 processing fee for copies 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:

____

Signature of Patient/Legally Authorized Representative:____

Date: ______________________________