MEDICAL RECORDS RELEASE

Patient Name:____Date of Birth: ________________________
Physician:___________________________Previous Name:____

I request and authorize: ____
Address: ____
City, State, Zip: ____
Phone/Fax number: ____

To release the medical records of the patient named above to:
Name:____
Address: ____
City, State, Zip: ____
Phone/Fax number: ____

This protected health information is being used or disclosed for the following purposes (or "at the request of the individual")

_____Company Physical _____Insurance Physical _____Pre-employment Physical
_____At the Request of the Individual _____Other (specify) ________________

This authorization shall be in force and effective until the following event and /or date:
____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the Privacy Contact, 400 W. Arbrook Blvd, Ste 301, Arlington, TX 76014.

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulation.

This practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use of disclosure.

____ ________________________
Signature of Patient or Personal Representative Date

____
Description of Personal Representative's Authority