McMorries

OBSTETRICS, GYNECOLOGY & INFERTILITY

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NACOGDOCHES, TX 75965

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: _____ Date of Birth: _____ Social Security #:_____

I authorize the following individual organization to disclose the above-named individual's health information: _____

_____Address: _____

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

_____Address: _____

For the purpose of:

_____

Please release the following:

__ Problem List __ Medication List __ X-Ray/Imaging Reports from (date) ____ to (date) ____

__ Progress Notes __ List of Allergies __ Laboratory Results from (date) ____ to (date) ____

__ History and Physical __ Complete Records __ Other Diagnostic Reports (specify), _____

__ Other (specify) _____

I understand that the information in my health record may include information relating the sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. __YES, I consent to the release of this Information, __NO, I do not consent to the release of this information.

I understand that the information released is for the specific purpose listed above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have the right to revoke his authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing the information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

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I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign the form in order to receive treatment. I understand that may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact _____

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship to Patient Date

COMPLETE ONLY IF INFORMATION IS BEING RELEASED TO PATIENT: I understand that my medical record may contain reports; test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold this office liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship to Patient Witness

Date request completed _____ #Pages_____ Reviewed only _____ Charges $_____ Cash _____ Check # _____ Initials _____