

RELEASE OF MEDICAL RECORDS

PATIENT LEGAL NAME _____

BIRTH DATE _____ SOCIAL SECURITY NO. _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

I HEREBY AUTHORIZE MEDICAL RECORD INFORMATION AND/OR *PROTECTED HEALTH* INFORMATION ON THE ABOVE PATIENT TO BE **SENT TO / REQUESTED FROM**: (circle option)

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE _____ FAX _____

_____ PHYSICIAN NOTES _____ OPERATIVE REPORT _____ PATHOLOGY REPORT

_____ IMAGING/RADIOLOGY REPORT _____ AUDIOLOGICAL TESTING _____ ALLERGY TESTING

FOR TREATMENT DATES _____

I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING, BUT IF I DO, IT WILL NOT HAVE ANY AFFECT ON ANY ACTIONS TAKEN PRIOR TO THIS OFFICE RECEIVING THE REVOCATION. FURTHER DETAILS MAY BE FOUND IN THE NOTICE OF PRIVACY PRACTICE.

IF THE REQUESTOR OR RECEIVER IS NOT A HEALTH PLAN OR HEALTH PLAN PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS AND MAY BE REDISCLOSED.

COPY FEES/CHARGES WILL COMPLY WITH THE TEXAS HEALTH AND SAFETY CODE, CHAPTER 241 AND ALL OTHER LAWS AND REGULATIONS APPLICABLE TO RELEASE OF INFORMATION.

I UNDERSTAND THAT TREATMENT AND PAYMENT ARE NOT A CONDITION OF SIGNING THIS AUTHORIZATION. I MAY RECEIVE A COPY OF THIS FORM AFTER I HAVE SIGNED IT.

I HAVE READ THE ABOVE AND AUTHORIZE THE DISCLOSURE OF THE PROTECTED HEALTH INFORMATION AS STATED.

DATE

SIGNATURE OF PATIENT/PARENT/PATIENT'S LEGAL REPRESENTATIVE

RELATIONSHIP

PRINTED NAME OF PATIENT/PARENT/PATIENT'S LEGAL REPRESENTATIVE

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

**WILLIAM B. COBB, M.D.
EWEN Y. TSENG, M.D.
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