USMD Health System | Imaging Centers

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO USMD

Name of Patient: _____ D.O.B._____ Age:____
LAST FIRST M.I.

I, _____, hereby authorize
(Name of patient or legal representative)

_____
(Name of person/entity who should release records)

_____
(Address of person/entity who should release records)

to release the following information by mail, fax, electronically or orally to:

USMD Diagnostic Services LLC

Address: _____ **Information is for:**

_____ ☐ Dr. _____

Phone: _____

Fax: _____

For the purpose of: _____

- ☐ All Health Information
- ☐ Statements of Charges or Payments
- ☐ AIDS or HIV Information *Initials* _____
- ☐ History and Physical Examination
- ☐ Copies of Records of Reports Provided to the Above Named (i.e. Hospital, Lab, Clinic, etc.)
- ☐ Mental Health and/or Alcohol & Drug Abuse Treatment *Initials* _____
- ☐ Progress Notes
- ☐ Substance Abuse Records *Initials* _____
- ☐ Genetic Information (inc. genetic test results) *Initials* _____
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Hepatitis Information
- ☐ Photographs, Videotapes, Digital, or Other Images
- ☐ Record of visit for a specific date(s). Specific dates include or are limited to:

_____

- ☐ Other (must be specific):

_____

This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time in writing, except where information has already been released.
4. USMD Diagnostic Services LLC, its employees, officers, and physicians are hereby released from any legal responsibility or liability for receipt of the above information to the extent indicated and authorized herein.
5. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws.
6. Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on obtaining this authorization.

_____ _____
Patient/Legal Representative Signature Date

_____ _____
Relationship to Patient Expiration Date of Authorization
unless otherwise noted, authorization expires 1 year from date of signature above

_____ _____
Witness Signature Date

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

_____ _____
Signature of Minor Individual Date