AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO USMD PHYSICIAN SERVICES

Patient Information

Patient's Full Name: _____ Phone: _____

Other Names(s) Used: _____ Date of Birth: ____ / ____ / _____

I authorize the following person or organization to disclose the protected health information of the above named patient to USMD Physician Services for the purpose of continuity of care.

Information is for Dr. _____ Phone: _____ Fax: _____

Person/Entity Who Should Release Records

Person/Entity: _____

Address: _____

Phone: _____ Fax: _____

What Information Can Be Disclosed

Complete the following by indicating those items you want disclosed.

- ☐ All Health Information
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Discharge Summary
- ☐ Operation Reports
- ☐ Diagnostic Reports (Lab, Radiology)
- ☐ Consultation Reports
- ☐ Other: _____

Your initials are required if you *DO NOT* want to release any of the following sensitive information:

_____ Mental Health Records (excluding psychotherapy notes)
_____ Genetic Information (including Genetic Test Results)
_____ Drug, Alcohol, or Substance Abuse Records
_____ HIV/AIDS Test Results/Treatment

This authorization is given freely with the understanding that:

1. A photocopy or fax of this authorization is as valid as this original.
2. I may revoke this authorization at any time in writing, except where information has already been released.
3. Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on obtaining this authorization.

Signature: _____ Date: _____
Signature of Individual or Individual's Legally Authorized Representative

Legally Authorized Representative

_____ _____
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