



AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION

Last Name (please print) _____ **First** _____ **M.I.** _____ **Date of Birth** _____ **Social Security Number** _____

I hereby authorize _____ to disclose the following specific information from my health record from (date) _____ to (date) _____.

Disclose to: (Name) _____ Phone: _____ Fax: _____
Address: _____ City: _____ State: _____ Zip: _____

Information to be disclosed (Please initial):

- Entire Health Record _____
- Operative Report _____
- Progress Notes _____
- Lab Test (specify & initial) _____
- Other (specify & initial) _____
- Consultation Report _____
- Biopsy Report _____
- History & Physical _____

For the purpose of (circle all that apply): Continuity of care /consultation /personal / insurance/ my request/ other (specify): _____

Disclosure to be: verbal _____ written _____

I understand if I do not authorize the release of my full health record, only a limited health record is provided per patient request. Provider will not require me to sign an authorization as a condition of my further treatment except where the treatment is for the purpose of research or solely for the purpose of creating a health record for disclosure to a third party and I refuse to authorize such disclosures.

I understand I may revoke this authorization in writing at any time, except to the extent that action has already been taken; forms are available. This authorization will expire 90 days from date of signature and I understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient. Woodlands Medical Specialist, P.A., and its employee's officers, and health care providers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.

I understand it may take 7 to 10 business days for this request to be processed. A copying fee of \$1 per page for the first 25 pages then \$.25 per page applies to my request. I further understand that I am entitled to a copy of the authorization.

Signature of Patient: _____ **Date:** _____ **Phone:** _____

Signature of Representative: _____

Witness: _____ **Date:** _____

_____ I DO _____ I DO NOT authorize the release of information, including, if applicable, specific laboratory tests of HIV infection (Human Immunodeficiency Virus, the causative agent of AIDS) or the diagnosis of Acquired Immune Deficiency Syndrome AIDS or AIDS related conditions. Signature implies authorization to fax records if expediency is required.

Please fax records ASAP to _____. Thank you for your cooperation, Woodlands Medical Specialists.

