AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: ____ Date of Birth: ___________________________

This form will authorize MaxHealth Family & Sports Medicine to provide a copy or summary of my medical records as indicated below:

Records to be released include:

_____ Records for the period of _____________ Through_________________

____ Lab Results; Date(s) ____

____ X-Ray Copies; Date(s) ________________Type _________________

____ Other: ____

You **must initial** if you consent to the release of the following information in conjunction with the rest of your medical records:	**Reason for Release of information:** ***(Choose all that apply)***
_______ AIDS or HIV Infection information	☐ Treatment/Continuing Medical Care
_______ Drug, Alcohol or Substance Abuse	☐ Personal Use
_______ Genetic Information (including Genetic Test Results)	☐ Billing or Claims
_______ Mental health information	☐ Insurance
	☐ Legal Purposes
	☐ Disability Determination
	☐ School
	☐ Employment
	☐ Other *(Specify)*: ______________________

The above information may be released to:

Persons/Organization(s): ____

Address: ____

City:____State:__________________________Zip_________________

Phone #____________________________________ Fax#:_____________________________________

Expiration of authorization: (You must specify a date or event, i.e. at the end of litigation)______________________________

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise required by law. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider or other entity considered a covered entity under HIPAA, the released information may no longer be protected by federal privacy regulations. I further understand that information disclosed pursuant to this authorization may be re-disclosed by the parties listed above and no longer protected. I have the right to revoke this authorization in writing except to the point that action has already been taken in reliance upon the authorization. I also understand that treatment or payment cannot be conditioned on the authorization.

Signature (Patient/Guardian): _______________________________________Date: ______________________________

5207 Heritage Avenue, Colleyville, Texas 76034 P 817.355.8000 F 877.878.7146 www.maxhealthmed.com

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REVOCATION SECTION:

I hereby revoke this authorization, effective _____/_____/_____.

____ ___________________________

Patient Signature Date

____ ___________________________

Printed Name of Patient

____ ___________________________

Signature of Practice Privacy Officer Date

If the Practice is seeking this authorization from you for a use or disclosure of your PHI, we will provide you with a copy of this signed authorization.

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