MaxHealth
Family, Internal & Sports Medicine

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

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

Facility name where records are located: _____

Facility address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

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:

MaxHealth Family & Sports Medicine
5207 Heritage Ave.
Colleyville, TX 76034
817.355.8000 phone
877.878.7146 fax

- ❑ Jeffrey M. Bullard, M.D.
- ❑ John A. Moorhead, M.D.
- ❑ Allison Phelps, MD
- ❑ Melinda Harrell, M.D.
- ❑ Tiffany Patton-Barnes, MS, LPC, BCN fellow
- ❑ Kelly Gonzales, P.A.-C.
- ❑ Stephanie West, P.A.-C., MPAS
- ❑ James Pitts, DC
- ❑ Alicia Townsend, PHD, LCP, BCN fellow

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: _____

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.