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 _____Drug, Alcohol or Substance Abuse _____Genetic Information (including Genetic Test Results) _____Mental health information	□ Treatment/Continuing Medical Care □ Personal Use □ Billing or Claims □ Insurance □ Legal Purposes □ Disability Determination □ School □ Employment □ Other *(Specify)*: _____

The above information may be released to:

MaxHealth Family, Internal
& Sports Medicine

5207 Heritage Ave.
Colleyville, TX 76034
817.355.8000 phone
817.391.1070 fax

❑ Jeffrey M. Bullard, MD
❑ Rashad Mohamed Riazuddin, MD
❑ Melinda Harrell, MD
❑ James Dominici, PA-C, MPAS
❑ Madeline Wingard, PA-C
❑ Jignesh "Jay" Mistry, PA
❑ Jennifer Pearlman, FNP-C
❑ Elise Woodside, FNP-C
❑ Brian Nimphius, DC
❑ Tiffany Patton-Barnes, MS, LPC, BCN Senior Fellow, QEEG Diplomat

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.