Texas Health
Center for Diagnostics & Surgery
PLANO

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency laboratory test results, medical history, treatment, or any other such related information. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive this information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

Patient Name: _____ SSN#: _____
Phone Number: _____ DOB: _____
Dates of Service (if known) _____

Description of information to be released: (Check all that apply)

__History and Physical __Operative Report __Nurse's Notes __Labs/Paths
__Consultation Report __Physician's Orders __Radiology Reports __Billing Records
__Discharge Summary __Progress Notes __Radiology Films/CD __Entire Chart
Other:_____

Description of the purpose of the use and / or disclosure: _____
_____

The health information described herein shall be released to (check the appropriate category)
___ Hospital ___Physician ___Insurance Company ___ Attorney ___Patient ___ Other

Medical Provider to release records:
Texas Health Center for Diagnostics & Surgery
6020 West Parker Road
Plano, Texas 75093
(972) 403-2700 (Main)

Persons/organizations receiving the information:
_____
Address:_____
_____
_____

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____ (Expiration date/event).

I further understand that I may revoke this authorization at any time by notifying the providing organization in writing and if I do it will not have any effect on any actions they took before they received the revocation.

I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. Further I understand there may be a fee for a copy of this information.

_____ _____
Signature of Patient or patient's representative Date
Printed name of patient's Representative_____
Relationship to patient _____

Please submit requests to: Texas Health Center for Diagnostics & Surgery, Attn: HIM Dept. 6020 West Parker Road · Plano, Texas 75093 or Fax (972) 403-2862

OFFICE USE ONLY: PATIENT HEALTH INFORMATION RELEASED BY_____DATE_____