



AUTHORIZATION TO RELEASE MEDICAL INFORMATION FROM USMD PHYSICIAN SERVICES

I, _____, hereby authorize
(Name of patient or legal representative)

USMD Physician Services to disclose the following information by mail fax orally to:

Name: _____
(Name of person/entity who should receive records)

Address: _____
(Address of person/entity who should receive records)

City, State, Zip Code: _____

Phone Number: _____ Fax Number: _____

From the health records of: _____
(Name of person whose record will be disclosed)

Name of Patient: _____ D.O.B. _____ Age: _____
LAST FIRST M.I.

For the purpose of: _____

My authorization extends only to those data elements/documents marked below:

- All Health Information
- Statements of Charges or Payments
- AIDS or HIV Information Initials _____
- History and Physical Examination
- Copies of Records of Reports Provided to the Above Named (i.e. Hospital, Lab, Clinic, etc.)
- Mental Health and/or Alcohol & Drug Abuse Treatment Initials _____
- Record of visit for a specific date(s). Specific dates include or are limited to: _____
- Progress Notes
- Substance Abuse Records Initials _____
- Genetic Information (inc. genetic test results) Initials _____
- Discharge Summary
- Consultation Reports
- Hepatitis Information
- Photographs, Videotapes, Digital, or Other Images

Other (must be specific): _____

This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time in writing, except where information has already been released.
4. USMD Physician Services, its employees, officers, and physicians are hereby released from any legal responsibility or liability for receipt of the above information to the extent indicated and authorized herein.
5. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws.
6. Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on obtaining this authorization.

Patient/Legal Representative Signature

Date

Relationship to Patient

Expiration Date of Authorization
unless otherwise noted, authorization expires 1 year from date of signature above

Witness Signature

Date

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

Signature of Minor Individual

Date