TAYLOR TEXAS MEDICINE
403 W. Campbell Rd, Suite 300
Richardson, TX 75080

Authorization For Release of Information

I hereby authorize _____to disclose 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 understand that this authorization is voluntary and I may refuse to sign this authorization. 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 the 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.

Print Patient Name _____
Birthdate _____/_____/_____ (mm/dd/yyyy) Social Security Number _____
Patient Address _____ Phone Number (____)_____
Date(s) of Service (if known) _____

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

____ Emergency Room
____ History & Physical
____ Nurse's Notes
____ Progress Notes
____ Discharge Summary
____ Radiology Reports
____ Consultation Reports
____ Physician's Orders
____ Operative Records
____ Radiology Films
____ Admission / Registration Records
____ Laboratory Reports
____ Billing Records
____ Other: _____
_____
_____
_____

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

The health information describe herein shall be released to: (Check ✓ all that apply)

____ Hospital ____ Physician ____ Insurance Company ____ Attorney ____ Patient ____ Other

(Check ✓ the appropriate delivery method)

Name_____
Address_____
City, State, ZIP_____
Phone # _____Fax #_____

____ Mail
____ Fax
____ Pick-Up Records
____ Other _____

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 this practice in writing at the address listed above. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____
Signature of Patient or Patient's Representative Date

_____
Printed Name of Patient's Representative

_____ or _____
Relationship to Patient Legal Authority (attach supporting documentation)