AUTHORIZATION OF USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Timarron Family Medicine, P.A.
200 Pecan Creek Dr
Southlake, TX 76092
Phone:817/481-4739 Fax: 817/481-5198

This authorizes Person(s):_____

Address:_____

City, State, Zip:_____

Phone:_____ Fax:_____

to provide a copy, summary or narrative of my medical records as indicated below by checkmark. The release of medical data includes re-disclosure of medical information obtained from other providers in accordance with the patient's wishes to ***Timarron Family Medicine, PA*** at the above address.

Patient Name:_____ DOB:_____
(Please Print)
Social Security #:_____

INFORMATION TO BE RELEASED

_ Dates of Service _____ _ Consultation Report _ Operative Report
_ Face Sheet _ Lab/Pathology Report _ X-ray Reports/Images
_ Immunizations _ All records _ _____

REASON FOR RELEASE OF RECORDS: _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of tobacco, drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee for copies of my medical records according to the Texas State Board of Medical Examiners.

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows:

Date:_____ Signature:_____
Patient or Legally Authorized Representative

_____
Printed Name of Patient or Legally Authorized Representative

_____
Relationship to Patient