AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FROM USMD PHYSICIAN SERVICES

Patient Information

Patient's Full Name:_______________________________ Phone: ____________________

Other Name(s) Used: _______________________________ Date of Birth: ______ /_____ / _________

Who Can Receive and Use the Health Information

I authorize USMD Physician Services to disclose the protected health information of the above named patient to:

Person/Organization Name: ____

Address: ____

Phone: ___________________________ Fax: ___________________________

Reason for Disclosure

- ☐ Treatment/Continuing Care
- ☐ Billing or Claims
- ☐ Legal Purposes ____________________
- ☐ Personal Use
- ☐ Insurance/Disability
- ☐ Other: ____________________

What Information Can Be Disclosed

Complete the following by indicating those items you want disclosed.

- ☐ All Health Information
- ☐ History/Physical Exam
- ☐ Diagnostic Reports (Lab, Radiology)
- ☐ Physician's Orders
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Progress Notes
- ☐ Billing Information
- ☐ Other ____________________
- ☐ Pathology Reports
- ☐ Operation Reports

Your initials are required if you *DO NOT* want to release any of the following sensitive information:

_______ Mental Health Records (excluding psychotherapy notes)

_______ Genetic Information (including Genetic Test Results)

_______ Drug, Alcohol, or Substance Abuse Records

_______ HIV/AIDS Test Results/Treatment

This authorization is given freely with the understanding that:

1. A photocopy or fax of this authorization is as valid as this original.
2. I may revoke this authorization at any time in writing, except where information has already been released.
3. 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.
4. 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

Please note: If you are a guardian or court appointed representative, you must attach a copy of your legal authorization to represent the patient, except in the case of the parent of a minor patient.

A minor patient'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 Patient Date

Submit completed form to:
Fax: 817-514-7879
Email: medical.records@usmd.com

or mail to:
Medical Records Department
909 Hidden Ridge Drive
MacArthur Ridge II, Suite 300
Irving, Texas 75038