

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize

(Entity/Person from Whom Records are Requested)

(Full and Complete Address)

(Phone Number and Fax Number if available)

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

Date of Birth

Social Security Number

Date(s) of service (if known): _____

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

- Hospital admission records / Operative records / Billing records / Discharge records
- Radiology reports & films Consultation reports Laboratory reports
- Emergency Room records Physician's orders Physician's notes & Progress notes
- History & Physical Nurse's notes Other: _____

Purpose of release of information: _____

The health information described herein shall be released to:

- Hospital **Physician** Insurance Company Attorney Patient Other

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Frisco, Texas 75035
Office: 972.377.0322 Fax: 214.975.8763

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 event/date)

I further understand that I may revoke this authorization at any time by notifying _____ in writing at
(Person/Entity from Whom Records are Requested)

(address). 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

Relationship to Patient

or Legal Authority (attach supporting documentation)