



Medical Records Authorization

RELEASE RECORDS TO:

Banks, Halderman, Allen, Kidd
Carter, Brogan Hall, Santamaria
4541 Medical Center Drive
McKinney, TX 75069
Phone (972)542-8884 Fax (214)544-9449

REQUEST RECORDS FROM:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

PATIENT INFORMATION:

Patient Name: _____
Date of Birth: _____ Social Security Number: _____
Address: _____ City: _____ State: _____ Zip: _____
Primary Phone #: _____ Secondary Phone #: _____

I authorize the above listed person/s, physician/s, firm or entity (or its agents, representatives, or employees) to release for inspection and copying, any and all of the Personal Health Information (PHI) listed below that pertains to my treatment, hospitalization, or care from the date/s of: _____ to _____.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Entire Record – Inpatient | <input type="checkbox"/> Radiology/X-Ray Reports | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Entire Record – Outpatient | <input type="checkbox"/> Newborn/Neonatal Records | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> ER Records |
| <input type="checkbox"/> Labor & Delivery Records | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Anesthesia Records | |

Other: _____

If requested by patient, purpose may be listed as “at the request of the individual.” The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire in 30 days. Payments made to NCWHP for PHI is not for financial gain but for compensation only. I do not have to sign this authorization in order to receive treatment from (list practice releasing PHI) _____. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at the contact information listed above.

REASON FOR REQUESTING RECORDS: _____

Signature of Patient: _____ Date: _____

Signature of Legal Representative: _____ Date: _____

Relationship to the Patient: _____

Special Authorization to Release HIV/AIDS, Mental Health and/or Drug Treatment Information

I hereby authorize my HIV/AIDS, Mental Health and/or Drug Treatment information to be released to the party listed above.

Signature _____ DOB _____ Date of Authorization _____