TEXAS PHYSICIANS GROUP
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name:______________________________ Medical Record #:__________

Date of Birth:______________ Social Security #: XXX-XX-__________

I authorize the following individual or organization to disclose the above named individual's health information:

______________________ Address:______________________________

This information may be disclosed TO and used by the following individual or organization: Ph : 806-788-0040 Fax :806-788-0015

Cardiologists of Lubbock Address: 4802 N Loop 289, Lubbock, TX 79416

For the purpose of:______________________________

Please release the following:

___Entire Record

or: ___Problem List
___Progress Notes
___History/Physical Exam
___Medication List
___Immunization Record
___List of Allergies
___X-Ray/Imaging Reports-from (date)________ to (date)_______
___X-Ray Films
___Laboratory Results-from (date)_________to (date)_________
___EKG Reports
___Genetic Testing Information
___Other Diagnostic Reports (Specify)____________________
___Other (Specify)______________________________

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

___**Yes**, I consent to the release of this information. ___ **No**, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date:______________________.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether or not I sign this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact ________________________*(insert privacy officer or other office or individuals name or contact information)*

______________________________ Signature of Patient or Legal Representative

______________________________ Date

______________________________ Relationship to Patient (If Legal Representative)

______________________________ Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold ____________________ liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

______________________________ Signature of Patient or Legal Representative

______________________________ Date

______________________________ Relationship to Patient (If Legal Representative)

______________________________ Witness

Date request completed:____________________ # pages copied:__________ Reviewed only__________

Charges: $______________ Cash__________Check #:______________ Initials__________