Patient Authorization Form / Release of Records

From Dr. or Clinic: _____
_____
_____

I hereby authorize the person(s) listed above to use or disclose the specific information described below, only for the purposes and parties also described below.

( ) Continuity of Care

( ) Other_____

Description of the specific information to be used or disclosed:

( ) Complete Medical Record
( ) Medical Records from _____ to _____date
( ) Labs
( ) Pap Smear
( ) Mammogram Report
( ) Other _____

Please send the above information to:

Damian Garcia, M.D.
3450 W. Wheatland Rd. POB II, Ste. 235
Dallas, TX 75237
Phone: (972) 224-1122 Fax: (972) 224-8084

This Authorization shall remain in effect from the date signed below, until: _____
(expiration date or event)

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting the office at the address listed above.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.

( ) if this is checked, I understand that you will receive compensation from a third party for the use of disclosure of my information.

_____
Patient Name

_____
Date of Birth

_____
Relation to patient
(if signed by Personal Representative)

_____
Signature

_____
Printed name of Personal Representative

_____
Date