# Texas Associates of Endocrinology and Diabetes, P.A.

## Authorization for Release of Medical Records

Type or print:
I hereby authorize Texas Associates of Endocrinology and Diabetes to release health records information on:

Name of Patient_____DOB_____

Address_____

Contact Phone #_____City/State/Zip_____

For Healthcare Covering the Period(s) from date_____to date _____

• May include other healthcare facility or healthcare providers' records? ☒Yes ☒ No

The purpose of this disclosure is for:

☐ **Continuance of Patient's medical care** ☒ **Attorney Review** ☒ **Insurance purposes**

☐ Other_____

Information to be disclosed may include:

☐ Copy of all health records to **include** HIV testing/results, mental health and/or alcohol or drug abuse records

☐ Copy of all health records to **exclude** HIV testing/results, mental health and/or alcohol or drug abuse records

☐ Specific records: **Progress Notes_____Laboratory Tests_____Radiology Reports _____ Other_____**

I understand that the information released as a result of this Authorization for Release of Protected Health Information (PHI) may be subject to re-disclosure and no longer protected by federal or state laws applying to medical information release.

I understand that there may be a fee for copying of my medical records if it is to be used for other than continuance of healthcare with another provider.

I understand that this Authorization may be revoked in writing at any time. I understand that revocation will apply only to releases of information made after the date of my revocation.

Unless otherwise indicated, this authorization will expire twelve months (12) from the date of signature. A photocopy of this authorization will be considered as valid as the original. I understand that I will be provided a copy of this Authorization by Texas Associates of Endocrinology & Diabetes upon request.

I understand and agree that my medical record will be maintained in a paper or electronic medical record (EMR) format and that records may be transmitted electronically via fax, E-mail, Internet, or data transfer system.

I understand that Texas Associates of Endocrinology & Diabetes cannot require me to sign this Authorization as a condition to providing services to me. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact my physician or Texas Associates of Endocrinology & Diabetes' Privacy Officer.

**TO:**

(This section will be filled out in case your records need to be sent to another physician. Please only sign and date.)

Physician name: _____

Address: _____

Phone:_____Fax: _____

Signature of Patient_____ Date _____

_____

(Relationship or status if signed by anyone other than patient, parent or legal guardian, personal representative, etc.)