

Texas Diabetes and Endocrinology, P.A.

Authorization From for Release of Protected Health Information

By signing this form, I authorize you to release confidential health information about me. I authorize you to release a copy of my medical records, a summary, or narrative of my protected health information, to the person(s) or entity listed below.

Patient Name: _____ Date of Birth: _____

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agents of AIDS with the rest of my medical records. Initial: _____ Date: _____

What health information do you want released?

Release my protected health information from the following person(s)/entity:

Name: _____

Address: _____

Phone: _____ Fax: _____

Release my protected health information to the following person(s)/entity:

Name: _____

Address: _____

Phone: _____ Fax: _____

The reasons or purposes for this release of information are as follows:

The authorization shall be in force and effective until the following event and/or date: _____

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to the rulings set forth by the Texas State Board of Medical Examiners.

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person:

Tiffany Reichle
6500 N. Mopac Expwy. Bldg III, Suite 200
Austin, TX 78731
512-458-8593 Phone 512-458-8593 Fax

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPPA privacy regulations.

The practice will not condition my treatment, payment, and enrollment in a health plan, or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority