 Cecilia Roman, FNP

 3106 South W.S. Young Drive Ste. B-203

 Phone: (254)833-5023 Fax: (254)554-8479

Authorization for Release of Information:

I hereby authorize the following information to be released form the medical record of:

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This Information needs to be Released :

To:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ From:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Check Information to be Released:

\_\_\_Progress Noted \_\_\_MRI Report \_\_\_Pathology Report

\_\_\_Lab report \_\_\_History & Physical \_\_\_Emergency Rm. Report

\_\_\_X-Ray Report \_\_\_Operative Report \_\_\_Other

I understand that to the extent any recipient if this information, as identified above is not a “covered entity” under Federal of Texas Privacy law, the information may no longer be protected by Federal or Texas law once it is disclosed to the recipient and m therefore, may be subject to re-disclosure by the recipient.

I understand that I may revoke this authorization in writing at any time except to the extent that the clinic of Cecilia Roman, FNP has already relied on this authorization, I understand that I may revoke this authorization by providing a written request for revocation stating my intent to revoke this authorization.

I understand that Cecilia Roman, FNP may not condition treatment on my completion of this authorization form.

If information that the clinic of Cecilia Roman, FNP is being released directly to me, I understand that my medical record contain reports, test results, and notes that only Provider can interpret. I understand that I have been advised that I should contact my Provider regarding that entries made in my medical records to misunderstandings of the information that has been written in the record, I will not hold the clinic of Roman Family Practice, PLLC or Cecilia Roman, FNP liable for any misinterpretation of the information in my record as a result of not consulting my provider for the correct interpretation. This authorization will expire in 180 days, or at the date or event specified here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I understand that the information released for the specific purposed stated above and may not be provided in whole or in part to any other agency, organization, or person.

Signature of Patient or Legal Representative Date

Representatives Authority to act for Patient Witness