**AUTHORIZATION FOR RELEASE OF INFORMATION**

STAR UOLOGY OF TEXAS, P.A. 20 Northgate Dr. Waxahachie, TX 75165

Phone: 214-980-1920 Fax: 214-980-1686

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_ Patient Account #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Instructions***: I authorize and request the disclosure of all protected information for the purpose of review and evaluation. I expressly request that the designated record custodian of all covered entities under HIPPA identified below disclose full and complete protected medical information including the following:

**DATES OF TREATMENT:** FROM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* All medical records meaning every page in my record
* Or specify from the following

\_\_\_Patient information/Insurance \_\_\_Office Visits \_\_\_Labs \_\_\_Radiology

\_\_\_Telephone Encounter \_\_\_Hospital Records \_\_\_Consult Notes

\_\_\_Records received by other medical providers \_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand the following to be released or disclosed to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

**PURPOSE FOR RELEASE OF INFORMATION:**

**\_\_\_\_** Transfer Records \_\_\_\_Continuing Care \_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELEASE MY RECORD:**

FROM: NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STREET:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY:\_\_\_\_\_\_\_\_\_\_\_\_\_STATE:\_\_\_\_\_\_ ZIP:\_\_\_\_\_\_\_\_\_

PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TO: NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STREET:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY:\_\_\_\_\_\_\_\_\_\_\_\_\_STATE:\_\_\_\_\_\_ ZIP:\_\_\_\_\_\_\_\_\_

PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I UNDERSTAND THE FOLLOWING:**

* **I have the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.**
* **The information released in response to this authorization may be re-disclosed to other parties.**
* **My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.**

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from the date of execution at which time this authorization expires.

**SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_**Patient**  \_\_\_**Parent** \_\_**Legal Guardian**

**PRINTED NAME**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE: \_\_\_\_\_\_\_\_\_ \_\_\_**Other** (Executor of state, power of attorney)

Authorization for Release of Information 01/07/2021