Patient Consent / Authorization for Release of Protected Health Information **FROM** Dallas Center for Pelvic Medicine

Patient Name:_____ Date of Birth:_____

Address:_____ City:_____ State:____ Zip Code:_____

Phone Number:_____ Last 4 digits of Social Security #: XXX-XX-_____

I hereby authorize the release of, or request access to, the Protected health Information specified in this request to the organization, doctor, agency or patient named below.

Release From: Name:_____
(Doctor, Hospital, Attorney, Insurance Company, Agency, Patient Name)

Address:_____

City:_____ State:_____ Zip Code:_____

Phone Number:_____ Fax Number:_____ ☐ Treatment Dates:_____

Released To: ☐**Brian A. Feagins, MD** ☐**Dan B. French, MD** ☐**Ginger Isom-Batz, MD**

Dallas Center for Pelvic Medicine ♦ 10501 N. Central Expwy ♦ Suite 200 ♦ Dallas, TX 75231 PH:(214) 360- 1537 x 7 Fax:(214) 360-1534

Purpose of Release:

☐ Personal Use ☐ Further/Continuing Medical Care ☐ Insurance ☐ Legal ☐ Workers' Comp

☐ Social Security Benefits ☐ Disability ☐ School ☐ Military ☐ Other/Specify_____

Pertinent Protected health Information Allowed to be included : ☐ **Entire Medical Record** ☐ **Entire Billing Record**

☐ Face Sheet / Demographics	☐ Hospital Reports	☐ Medication Record	☐ Lab/Pathology Reports
☐ History & Physical/Consult	☐ Operative Reports	☐ Physicians Orders	☐ EKG
☐ Outpatient Records	☐ Progress Notes	☐ Radiology Rpts/Images	☐ Special Studies
☐ Care Plan	☐ Discharge & Summary	☐ Psych Records	☐ ER Records
☐ Medication Record	☐ Billing Records	☐ Other(Specify):_____	

FOR DCPM USE ONLY
□ **Mail Copies**
Date:_____
□ **Faxed Copies**
Date:_____
Fax #_____
□ **FedEx Copies**
Date:_____
Trk#_____
□ **Patient Pick-Up**
Date:_____
□ **Other Authorized Pick-up**
Name:_____
Date:_____

Authorization: I understand that this request authorizing disclosure of health information is made voluntary and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this consent/authorization at any time in writing by submitting my request in writing to the designated Health Information Management / Medical Records Department except to the extent that action has been taken in reliance upon the original authorization. I understand that according to applicable state and/or federal laws (Texas Medical Practice Act or Health Insurance Portability and Accountability Act [HIPAA], a re-disclosure could be made of records received from another physician or other healthcare provider involved in my care or treatment. A copy of this authorization will as valid as the original. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my health information has acted in reliance upon this authorization.
Voluntary: I understand that authorizing disclosure of health information is voluntary. I understand that I may refusal to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee may be charged for copes of my medical record. I understand that the facility will provide me a copy of the signed authorization forma. If I have questions about disclosure of my health information, I can contact the designated Corporate Responsibility and Privacy Officer.
Expiration: Without my express written revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expired 90 days from the date hereof, unless a different date is specified here:_____.
Acknowledgement: I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency viruses (HIV) also know as acquired immune deficiency syndrome (AIDS). The facility, its employees, officers, and attending physician(s) are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Signature:_____ **Date:** _____ **Printed Name**_____
☐**Patient or** ☐**Legal Representative/Guardian**
***Minor's signature is required for release of any records for treatment which the minor may authorize under Colorado Law**

Relationship if other than patient:_____ ☐ **Power of Attorney** ☐ **Death Certificate**

Name of individual signing on behalf of patient:_____

Verification: ☐ **Drivers License #**_____ **State:**_____ ☐ **Other Appropriate ID:**_____

I understand the retrieval/processing fee for copies of my Protected Health Information is according to Texas Administrative Code §165.2
(a) $25.00 for the first 20-pages (b) $0.50 for each additional page (c) $15.00 for executing each Affidavit (d) Postage
(e) Billing records are a separate cost

Records will be furnished within 15-business days for receipt of signed HIPAA approved release authorization and payment of processing and copying fees. Texas Administrative Code Rule §165.2