Patient Consent / Authorization for Release of Protected Health Information TO 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-______________

Date of Request:__________________________ Treatment Dates:__________________________________

I hereby authorize the release of, or request access to, the Protected health Information specified in this request 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) 360-1535 FX: (214) 360-1534

Release from:____ **(Organization, Agency, Doctor, Individual)**

Address:_____________________________________ **City**______________ **ST**_____ **Zip code:**________

Delivery Instructions: ☐ **Mail Copies to Address above** ☐ **Fax Copies (214) 360-1534** ☐ **Call to pick up Copies:**__________________

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):________________	

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:**________________