HA GRAND MD PA

3801 Gaston Ave., Suite 315
Dallas, Texas 75246
Phone: (214) 824-2121
Fax: (214) 824-2406

Authorization to Disclose Health Information To

Patient Name: _____

Date of Birth: _____ Phone Number: _____

_____
Name of Provider/ Clinic/ Organization

_____
Street Address *City* *State* *Zip code*

_____
Phone *Fax*

Please MAIL or FAX Information To:
HA Grand MD PA
3801Gaston Ave., Suite 315
Dallas, Texas 75246
Phone: (214) 824-2121
Fax: (214) 824-2406

I AUTHORIZE the following information to be disclosed (please check all that applies):

_____ Entire Medical Record
_____ Immunization Record
_____ Lab/ EKG Tests
_____ TB Test
_____ HIV Record
_____ STD Record
_____ Alcohol/Substance Use
_____ Psychiatric/ Mental Health
_____ Billing Records
_____ Other

REASON for disclosure of Health Information (please check all that apply):

_____ At My Request
_____ Continuing Care
_____ Legal
_____ Change of Physician
_____ Employment
_____ School
_____ Insurance
_____ Other

This Authorization to Disclose Health Information Expires 90 days from Patient's Signature Date.

I, _____ (print name), understand that I have the right to withdraw this authorization by completing the section below. I understand that I do not have to sign this authorization to get treatment from HA Grand MD PA. I understand that once my health care information is disclosed as I have authorized, it could be disclosed by the recipient and is no longer protected by HA Grand MD PA. I understand that signing this authorization does not exempt me from any rights I have with other states or Federal Laws.

_____
Patient Signature/ Legal Representative *Date*

_____
I wish to withdraw the authorization *Date*