



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 From

Patient Name: _____

Date of Birth: _____ Phone Number: _____

Please FAX Information From:

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

Information is to be released to the following:

Name of Provider/ Clinic/ Organization

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

Phone *Fax*

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Entire Medical Record | <input type="checkbox"/> HIV Record | <input type="checkbox"/> Billing Records |
| <input type="checkbox"/> Immunization Record | <input type="checkbox"/> STD Record | <input type="checkbox"/> Other |
| <input type="checkbox"/> Lab/ EKG Tests | <input type="checkbox"/> Alcohol/Substance Use | |
| <input type="checkbox"/> TB Test | <input type="checkbox"/> Psychiatric/ Mental Health | |

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

- | | | |
|--|--|------------------------------------|
| <input type="checkbox"/> At My Request | <input type="checkbox"/> Change of Physician | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Continuing Care | <input type="checkbox"/> Employment | <input type="checkbox"/> Other |
| <input type="checkbox"/> Legal | <input type="checkbox"/> School | |

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

I, _____ (print name), understand that I may revoke this authorization before 90 days. If revocation is not received in writing, this authorization will be considered valid for a period of time not to exceed 90 days. HA Grand MD PA and its employees are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized.

Patient Signature/ Legal Representative *Date*

I wish to withdraw the authorization *Date*