AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____ Medical Record # _____

Date of Birth _____ Social Security # _____(optional)

I authorize the following individual or organization to disclose the above named individual's health information:

From:

_____

_____

_____

To:

MYRNA C. DE ASIS, M.D.
1819 TENTH STREET
WICHITA FALLS, TX 76309
TEL. (940) 763-8077
FAX (940) 763-8078

Purpose or Need for Disclosure:

___ Continued Patient Care
___ Personal Use
___ Attorney/Legal
___ Insurance Claim/Application
___ Disability Determination
___ Other (Specify)_____

Please release the following:

___ Problem List
___ Progress Notes
___ History/Physical Exam
___ Medication List
___ Immunization Records
___ List of Allergies
___ X-Ray/Imaging Reports-from (date) _____ to (date) _____
___ X-Ray Films
___ Laboratory Results-from (date) _____ to (date) _____
___ EKG Reports
___ Genetic Testing Information
___ Other Diagnostic Reports (Specify) _____
___ Other (Specify) _____

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:
_____.

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFT 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness