AUSTIN SURGEONS, P.L.L.C.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ Account/Health Record Number: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:

   Name:_____

   Address_____ Phone: _____ Fax: _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

   _____ problem list
   _____ medication list
   _____ list of allergies
   _____ immunization records
   _____ most recent history and physical
   _____ most recent discharge summary
   _____ laboratory results from (date) _____to (date) _____
   _____ x-ray and imaging reports from (date) _____to (date) _____
   _____ consultation reports from (doctor's names) _____
   _____ entire record

   Other_____

4. _____

   I understand that the information in my health record may include information relating to sexually transmitted disease, 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.

5. This information may be disclosed to and used by the following individual or organization:

   Name: _____
   Address: _____
   Phone:_____Fax:_____
   For the purpose of _____

6. 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 health information management department. I understand that the revocation will not apply to information that has already been 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"***

7. 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 assure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information my not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the office manager at extension #215.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

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