Medical Records Authorization

RELEASE RECORDS TO:

Dr Banks Dr Halderman Dr Kidd Dr Fadahunsi

6609 Virginia Parkway

McKinney, TX 75071

Phone (972)542-8884 Fax (214)544-9449

REQUEST RECORDS FROM:

Name: ____

Address: ____

City: __________________State: _____ Zip: ____________

Phone: ______________________ Fax: ________________

PATIENT INFORMATION:

Patient Name: ____

Address: ____

City: ____________________________________ State: ____________________________ Zip: ____________________________

Primary Phone #: ___________________________________ Secondary Phone #: ____

Date of Birth: ___________________________________ Social Security Number: _______________________________________

I, ____ authorize the above listed person/s, physician/s, firm or entity (or its agents, representatives, or employees) to release for inspection and copying, any and all of the Personal Health Information (PHI) listed below that pertains to my treatment, hospitalization, or care from the date/s of: _______________ to ________________.

□ Entire Record – Inpatient □ Radiology/X-Ray Reports □ Operative Reports □ Pathology Reports

□ Entire Record – Outpatient □ Newborn/Neonatal Records □ Laboratory Reports □ ER Records

□ Labor & Delivery Records □ Discharge Summary □ Anesthesia Records

Other: ____

If requested by patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire in 30 days. The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. I do not have to sign this authorization in order to receive treatment from ____. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at the contact information listed above.

REASON FOR REQUESTING RECORDS: ____

Signature of Patient or Legal Representative: ____________________________________ Date: ____________________________

Special Authorization to Release HIV/AIDS Information

☐ I hereby authorize my HIV/AIDS information to be release to the party listed above.

Signature ____ DOB ________________ Date of Authorization ______________