HIPAA COMPLIANT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: ____Date of Birth:__________________

This letter will authorize Texas Regional Urology to _____ Release to or to _____Obtain from any listed provider or facility a copy, summary, or narrative of my medical records (as) indicated by the check mark(s) below) or to otherwise release confidential information. At this time I am requesting the following:

- ☐ Complete record
- ☐ Records of care from ______________________ to _________________ only
- ☐ Records of care concerning the following condition(s)___________________________________
- ☐ Other (Specify):____

Name of Physician/ Medical Facility: ____

Address: ____

Phone : __________________________________ Fax: ____

Reason for request : ____

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 mental health services, and treatment for alcohol and drug abuse.

_____Yes, I consent to the release of this information. ____No, I do not consent to the release of this information.

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. 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 you will provide this information within 15 business days from receipt of request, and you may charge a fee for preparing and furnishing this information. The fee is waived because the records are to be used for supporting an application for disability or other benefits or assistance under Aid to Families with Dependent Children, Medicaid, Medicare, Supplemental Security Income, and Federal Old-Age and Survivors Insurance. I have attached a statement which confirms that such an application or appeal has been filed or is pending.

Signed:____ Date: ____________

(Patient or person legally authorized to consent on patient's behalf)

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Tomball, TX 77375-3336
281-516-6530

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The Woodlands, TX 77380
832-442-2392

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281-570-1391