



# Medical Records Authorization

**REQUEST RECORDS FROM:**

*Dr Banks Dr Halderman Dr Allen Dr Kidd*  
*6609 Virginia Parkway*  
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*Phone (972)542-8884 Fax (214)544-9449*

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 \_\_\_\_\_