



Texas Medical & Surgical Associates, P.A.
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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Please Print or Type)

Patient Name: Social Security Number:
Address: Date of Birth:
City, State, Zip: Phone Number:

I hereby authorize Texas Medical & Surgical Associates, P.A. to release information from my medical record by

Mail Fax Email to:

Name
Address
City, State, Zip
Fax Number Email Address

Purpose of this Release:

My authorization is confined to the following specific information initialed below:

- Statements for charges or payments
Progress notes
Discharge summary
Consultation reports
Records or reports of visits for specific date(s) of:
Photographs, digital, or other images
History and physical examination
All of the above
Other (Must be specific)
Mental health and/or alcohol and drug abuse treatment
AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) information
Hepatitis information
Records or reports for visits (all visits)

This authorization is given freely with the understanding that:

- 1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available upon request.
4. Texas Medical & Surgical Associates, P.A., its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure for the above information to the extent indicated and authorization herein.
5. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon this authorization.
6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

PATIENT OR PERSONAL REPRESENTATIVE'S NAME PRINTED

DATE, EVENT, OR CONDITION OF EXPIRATION (IF OTHER THAN ONE YEAR FROM DATE SHOWN ABOVE)

PATIENT OR PERSONAL REPRESENTATIVE'S SIGNATURE

DATE

WITNESS

DATE