AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient Name: ____ **Phone Number:**__________________________

Other Names Used: ____ **Date of Birth:** __________________________

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above-named patient.

PATIENT INFORMATION IS NEEDED FOR: (Please select one option.)
☐ Continuing Medical Care ☐ Military ☐ Insurance
☐ Legal Purposes ☐ Other: ______________________________________

DATE(s) OF TREATMENT: ____

INFORMATION TO BE RELEASED OR ACCESSED:
☐ Consultation & Medical Notes ☐ Radiology/Imaging Reports
☐ Operative/Procedure Reports ☐ Other: ___________________________________
☐ Lab/Pathology Reports

FORMAT REQUESTED FOR INFORMATION TO BE PROVIDED:
☒ Paper

METHOD OF DELIVERY:
☒ Mail to Requesting Address Listed Below

David A. Stone, DO, PA 3000 S. Hulen Street, Suite 124, Fort Worth, Texas 76109
Doctor Office

May release the above information to:

____
Name

____
Address (Street, City, State, Zip Code) Phone Number

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses and/or treatment of drug or alcohol abuse, mental illness or communicable disease including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).
I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.
I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas law.
This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event or condition as follows: ____

____
Signature of Patient or Legally Authorized Representative | Printed Name of Patient or Legally Authorized Representative | Date

____
For Office Use: MRN/Acct # | Relationship to Patient