

## Authorization for Release of Patient Health Information

I hereby authorize \_\_\_\_\_ to disclose my individually identifiable health information as described below, which may include information concerning communicable disease such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

Name:	D.O.B.	SS#:
Address:	City	State
	Zip:	Telephone#:

I understand that if the recipient authorized to receive the information is not a health plan or healthcare provider; the released information may no longer be protected by federal and state privacy regulations.

Description of information to be released (check all that applies)

Entire Medical Record <input type="checkbox"/>	Pathology Reports <input type="checkbox"/>
Discharge Summary <input type="checkbox"/>	Laboratory Reports <input type="checkbox"/>
History & Physical <input type="checkbox"/>	Human Immunodeficiency Virus (HIV) or (HIV) Acquired Immune Deficiency Syndrome <input type="checkbox"/>
Radiology Reports <input type="checkbox"/>	Diagnostic Reports <input type="checkbox"/>
Consultation Reports <input type="checkbox"/>	Mental Health Records <input type="checkbox"/>
Physician's Orders <input type="checkbox"/>	Progress Notes <input type="checkbox"/>
Operative Reports <input type="checkbox"/>	
Others: (please specify) _____	

The patient has requested this disclosure for his/her physician.

The information described herein should be sent to the following address:

**Memorial Bone & Joint Clinic**  
**909 Frostwood, Suite #251**  
**Houston, TX 77024**  
**713-827-9316**  
**(f) 713-827-8345**

I understand that this authorization will expire one year from the date it is signed.

I understand that I may revoke this authorization at any time by submitting my request in writing to the above listed address

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Date: month/day/year

\_\_\_\_\_  
Printed Name of Patient's Representative

\_\_\_\_\_  
Relationship to Patient

or

\_\_\_\_\_  
Legal Authority (attach supporting documents)