Authorization to Release Protected Health Information
FROM Texas Diabetes & Endocrinology, P.A.

Texas Diabetes & Endocrinology is authorized by me to obtain or disclose my Protected Health Information for a purpose (described in this document) other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment in a health plan, or eligibility for benefits may not be conditioned upon me signing this authorization.

I specifically authorize Texas Diabetes & Endocrinology and/or the specified entity to obtain or disclose my Protected Health Information as described on this form to the recipient(s) listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization, if done according to the steps set forth below.

Please note: ALL sections must be completed to be a valid authorization.

Section I - Patient Information:

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Alternate Phone: _____

Section II – Release Information to:

I hereby authorize Texas Diabetes & Endocrinology to release my medical records to:

☐ Mail ☐ Fax ☐ CD ☐ Email *(please also complete & return an Email Consent Form)*

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____ Email: _____

Section III – Purpose(s) of Request:

☐ Personal ☐ Continuing Care (progress to PCP or referring physician) ☐ Insurance ☐ Legal

☐ Terminating care with Texas Diabetes/Transferring out: (Reason? _____)

☐ Other: _____

Section IV – Information to be Released *(Mark all that apply)***:**

Service Dates *(Optional)* from: _____ to: _____

☐ 2 year abstract (includes 3-6 months of diagnostics)
☐ Lab Reports
☐ Current Medications List
☐ Billing Information
☐ Other: _____

☐ Progress Notes
☐ Imaging Reports
☐ Problem List
☐ ALL Health Information**

Section V – Authorized to Release Protected Information:
*Note: Initials are required to release the following information**:*

☐ Mental Health Treatment ☐ Alcohol and/or Substance Abuse Treatment*_____

☐ HIV/AIDS Tests & Related Information* _____ ☐ Hepatitis C Tests & Related Information*_____

☐ Genetic Information (including, but not limited to, Genetic Test Results)* _____

Section VI – Right to Revocation:
I have the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization. Texas Diabetes & Endocrinology must receive the revocation in writing (and the written revocation must include:)

a) My name and address,
b) The effective date of this authorization, and the recipients of the Protected Health Information according to this authorization,
c) My desire to revoke this authorization, and
d) The date of the revocation, and my signature.

ALL written revocations must be sent to:

Misha Diden
6500 N Mopac, Bldg 3, Ste 200
Austin, TX 78731
Phone: 512-458-8400

Attention: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms listed above.

- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older, but is incapable of signing,** a legally authorized representative may sign and date the form. Please indicate your legal authority below and include documentation of your relationship.
- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship below. **By signing, I hereby state that my parental rights have not been revoked by a court of law.**

_____ _____
Signature of Patient or Patient's Legal Representative **Date***

_____ _____
Printed Name of Patient's Legal Representative (if applicable) **Relationship to Patient**

**This Authorization is valid for 90 days (30 days for alcohol/drug abuse treatment) unless you specify otherwise. See section VI for detailed instructions.*
*** I understand that checking the box for "ALL Health Information" authorizes Texas Diabetes & Endocrinology to mail my protected health information to the address listed above IF there are more than 100 pages in my record.*

FOR OFFICE USE ONLY:

☐ Authorization added to the patient's medical record on: _____.

☐ Patient has been provided with a copy of the signed authorization.