Authorization to Release Protected Health Information
TO 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.

Patient Name: ____ Date of Birth: ________________________

Patient Address: ____ Phone: ______________________________

City: __________________ State: _________________ Zip: __________________ Alternate Phone: _____________________

Information may be released to:

Texas Diabetes & Endocrinology / Dr. ________________
Medical Practice/Doctor

ATTENTION: MEDICAL RECORDS

110 Deer Ridge Drive, Round Rock, TX 78681
Address, City, State, Zip

(512)458-8400, option 5 (512)372-1074
Phone Fax

Information may be released from:

____
Medical Practice/Doctor

____
Address

____
City, State, Zip

____
Phone Fax

Please release the following information *(Mark all that apply)*:

☐ Problem List ☐ Imaging Reports ☐ Mental Health ☐ Outside Records
☐ Progress Notes ☐ Ultrasound Images (on CD) ☐ Drug/Alcohol ☐ Other (specify):
☐ History & Physical Exam ☐ Lab Reports ☐ HIV/AIDS Testing _________________
____

☐ Other Diagnostic Reports (specify):____

This information is necessary for the following purpose:

☐ Continued Patient Care ☐ Personal Use ☐ Attorney/Legal
☐ Insurance ☐ Other (specify): ____

1. I understand that the information in my health record may include information to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this in order to assure treatment. I understand that with certain exceptions I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

3. I understand that I have the right to revoke this authorization at any time. I understand that the revocation will not apply to the information that has already been released in response to this authorization. I understand that information released to Texas Diabetes & Endocrinology may be subject to re-disclosure and may no longer be protected by federal and state privacy regulations. I understand that this authorization shall remain effective indefinitely unless otherwise stated ____________________ (Date of Expiration), except to the extent that action has been taken in reliance on this authorization, by providing written notice to:

   Misha Diden
   6500 N Mopac, Bldg 3, Ste 200
   Austin, TX 78731

____ ________________________________

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

____ ________________________________

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

FOR OFFICE USE ONLY:

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

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