AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:
Patient Name: (Print) _____ Date _____
Date of Birth_____ Social Security # _____
Address: _____

From: Bradley B. Price M.D.
2911 Medical Arts St #6 Austin, TX 78705
Phone (512)476-6691 Fax (512)476-5607

To: Doctor/Hospital_____
Address_____
Phone_____ Fax_____

Please release the following:

____Problem List
____Progress Notes
____History/Physical Exam
____Medication List
____All records
____Other (specify) _____

_____OB care from (date) _____to (date) _____
_____Mammogram reports _____
_____Laboratory Results from (date) _____
_____Annual Exam _____
_____ Surgery _____

I understand that the information in my health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health service, and treatment for alcohol and drug abuse.
_____Yes, I consent to the release of this information. _____No, I do not consent to the release of this information.
I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a clam under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____
If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sight this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. 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. If I have questions about disclosure of my health information, I can contact Inez Price Phone # (512)476-6691

_____ _____
Signature of Patient or legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:
I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold_____ liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient(If Legal Representative Witness

Date request completed_____ # pages copied_____ Reviewed only_____
Charges $_____ Cash_____ Check#_____ Initials_____