AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient Name:		Phone Number:			
Other Names Used:	Date of	Date of Birth: Social Security Number: XXX			
I, the undersigned, authorize patient.	e the release of or request access	to the information specified belo	w from the medical re	cord (s) of the above-named	
PATIENT INFORMATION IS	S NEEDED FOR: PLEASE SELEC	CT ONE OPTION			
□ Continuing Medical Care□ Legal Purposes		☐ Personal Use☐ Other:	□ School	□ Insurance	
DATE (s) OF TREATMENT	;				
INFORMATION TO BE REI	EASED OR ACCESSED:				
□ Clinic Notes □ Procedure Notes	☐ Consultation Report	□ Immunizations	□ Al	l Records	
☐ Procedure Notes	□ EKG Reports	☐ Medication/Prescripti	on List		
□ Lab/Pathology Reports	□ Radiology Reports	□ Problem List			
☐ Behavioral Health		□ Other			
FORMAT REQUESTED FO	R INFORMATION TO BE PROVI	DED:			
☐ Paper ☐ Electronic med (* only applies to data stored	ia, as available * □ Release to Md electronically)	lyChart account, as available*			
METHOD OF DELIVERY: □ Pick Up (You will be noti □ Mail to Address listed belo □ Fax (Provide recipient info		ords are ready for pick up)			
Physician/Clinic name to rel May release the above info		Address & Phone			
	Institute fo	or Digestive Health			
		I.D. Henry Heiser, M.D.			
		arker Road, Suite 406			
		Гехаs 75093-7969			
	· · · · · · · · · · · · · · · · · · ·	-9494 Fax: 972-820-7772			
Information used or disclose that the specified information illness, or communicable dis I understand that treatment participation in research prothis authorization in writing a	s are confidential and cannot be or depursuant to this authorization man to be released may include, but is sease, including Human Immunod or or payment cannot be condition grams, or authorization of the releat any time except to the extent the notice of my medical.	ay be subject to re-disclosure by to some some some some some seficiency Virus (HIV) and Acquire and on my signing this authorizates of testing results for pre-empetat action has been taken in relian	the recipient and no look, and/or treatment of conditional distribution, except in certain sloyment purposes. It is not upon the authorization is not upon the authorization.	nger protected. I understand Irug or alcohol abuse, mental Syndrome (AIDS). n circumstances such as for understand that I may revoke	
charged a retrieval/processi	ng ree and for copies of my medic	cal records according to Texas Ho	ospitai Licensing law.		
This authorization will expire unless otherwise specified by	e One Hundred Eighty (180) days by date, event, or condition as follo	from the date of my signature un	less I revoke the auth	orization prior to that time or	
Date:	Signature:				
	•	Patient or Legally	Authorized Represen	tative	
		Printed Name of Patient	or Legally Authorized	I Representative	
For Department Use: MRN/	Acct #	Relationship to Patient			
		OR RELEASE OF PATIENT INFO 04/18) PAGE 1 of 1	_	TENT IDENTIFICATION	

Texas Health Physician Group

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