

Plano Internal Medicine Associates, PA

Authorization for Release of Patient Information

Patient Name: _____

Date(s) of Service: _____

Date of Birth: _____

Social Security #: _____

I, the undersigned, authorize the release of, or request access, to the information specified below **FROM:**

Plano Internal Medicine Associates, PA
6300 West Parker Road, Suite 220
Medical Office Building 2
Plano, Texas 75093

Attn: Gary Tigges, MD
 Son Giep, MD
 Shelly Heidelbaugh, MD

Purpose of Release:

- | | | |
|--|---|---|
| <input type="checkbox"/> Continuing Medical Care | <input type="checkbox"/> Military | <input type="checkbox"/> Social Security/Disability |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Personal Use | <input type="checkbox"/> School |
| <input type="checkbox"/> Legal Purposes | <input type="checkbox"/> Other (please specify) _____ | |

Information to be Released or Accessed:

- | | | |
|--|---|--|
| <input type="checkbox"/> Face Sheet | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Care Pan | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Lab/Pathology Reports |
| <input type="checkbox"/> EKG Reports | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Hospital Reports | <input type="checkbox"/> Medication Record | <input type="checkbox"/> ER Reports |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Other (please specify) _____ | |

The above information may be released **TO:**

(Specify name of the individual or organization to which records are to be released and the appropriate address):

Name (Doctor, Hospital, Attorney, Insurance Company, Self, etc.)	Phone Number	Fax
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Address (Street, City, State, Zip)

I understand that my records are confidential and cannot be released or disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable diseases, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time.

I understand that I have the right to receive a copy of this authorization.

I understand that my provider indicated above will provide this information within 15 days from receipt of request. I understand I may be charged retrieval/processing fee if my records are located at off-site storage. I also understand that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

Date: _____

Signature: _____

Patient or Legally Authorized Representative

Printed Name of Patient or Legally Authorized Representative

For Internal use: Acct/MRN#

Relationship to Patient