Plano Internal Medicine Associates, PA

Authorization for Release of Patient Information

Patient Name: ______________________________________

Date of Birth: ______________________________________ Social Security #: _______________________

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

____
Name (Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number Fax

____
Address (Street, City, State, Zip)

Purpose of Release:
□ Continuing Medical Care □ Military □ Social Security/Disability
□ Insurance □ Personal Use □ School
□ Legal Purposes □ Other (please specify) _____________________________________

Information to be Released or Accessed:
□ Face Sheet □ History & Physical □ Progress Notes
□ Care Pan □ Radiology Reports □ Lab/Pathology Reports
□ EKG Reports □ Consultation Reports □ Operative Reports
□ Hospital Reports □ Medication Record □ ER Reports
□ Discharge Summary □ 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):

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

Attn: □ **Gary Tigges, MD**
□ **ThuHa Pham, MD**

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

PLEASE MAIL RECORDS UNLESS OTHERWISE REQUESTED.

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Relationship to Patient