



AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d) effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information.

NAME OF PATIENT OR INDIVIDUAL

Last First Middle

OTHER NAME(S) USED

DATE OF BIRTH Month Day Year

ADDRESS

CITY STATE ZIP

PHONE ALT. PHONE

EMAIL ADDRESS (Optional):

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name Address City State Zip Code Phone Fax

REASON FOR DISCLOSURE (Choose only one option below)

- Treatment/Continuing Medical Care
Personal Use
Billing or Claims
Insurance
Legal Purposes
Disability Determination
School
Employment
Other

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name BrainDocs, PLLC Address 2620 Long Prairie Road, Suite #100 City Flower Mound State Texas Zip Code 75022 Phone 817 240-0012 Fax 972 821-3677

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed.

- All health information
Physician's Orders
Progress Notes
Pathology Reports
History/Physical Exam
Patient Allergies
Discharge Summary
Billing Information
Past/Present Medications
Operation Reports
Diagnostic Test Reports
Radiology Reports & Images
Lab Results
Consultation Reports
EKG/Cardiology Reports
Other

Your initials are required to release the following information:

Mental Health Records (excluding psychotherapy notes) Genetic Information (including Genetic Test Results) Drug, Alcohol, or Substance Abuse Records HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional):

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION."

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission.

SIGNATURE X Signature of Individual or Individual's Legally Authorized Representative DATE

Printed Name of Legally Authorized Representative (if applicable): If representative, specify relationship to the individual: Parent of minor Guardian Other

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X Signature of Minor Individual DATE