AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

TEXAS PLASTIC SURGERY ASSOCIATES
7777 Forest Lane, Suite C-504
Dallas, TX 75230
Phone: 972-566-3939 Fax: 972-566-3999

PATIENT NAME:_____ **DATE OF BIRTH**:_____

Address:_____

I*_____*hereby authorize Texas Plastic Surgery Associates, Dr. Frederick J. Duffy Jr, MD and/or Dr. Brice McKane to release or disclose my medical records/protected health information as indicated below:

SCOPE OF ACCESS REQUESTED

☐ All the records ***or*** ☐ The portion of the records concerning:

_____

_____

_____

(Specify type of disease, accident, dates of treatment, or other portion of records you are interested in.)

☐ Please send copies to a health provider

NAME:_____

ADDRESS:_____

PHONE:_____FAX:_____

(Name, address and phone number of health care provider or other individual to whom the records are to be delivered)

☐ Held at the front desk so I can pick them up

☐ Mailed to me at: [insert address]_____

REASON FOR RELEASE OF INFORMATION

____Treatment/continuing care ____Personal Use ____Billing/Insurance

____Legal Purposes ____Disability Claim ____School/Employment

The individual signing this form agrees and acknowledges as follows:

Voluntary Authorization: This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

Effective Time Period: This authorization shall be in effect for 1 year from the date this authorization is signed or the following specified date:
Month: _____ Day: _____ Year: _____.

Right to Revoke: I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

Signature Authorization: I have read this form and agree to the uses and disclosure 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. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

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.

Signed: _____ **Date:** _____

Print Name: _____ **Telephone:** _____

If not signed by the patient, please indicate relationship:

- ☐ parent or guardian of minor patient (to the extent minor could not have consented to the care)
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient