TEXAS ORTHOPAEDIC ASSOCIATES, L.L.P.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____ Date of Birth _____

I authorize the following individual or organization to disclose the above named individual's health information:

Texas Orthopaedic Associates Address: 5701 Bryant Irvin Road Suite 202 Fort Worth, Texas 76132

This information may be disclosed TO and used by the following individual or organization:

UT Orthopedics
Attn: Dr John Conway or Cynthia Plitt Address: 6400 Fannin Street Suite 170 Houston, Texas 77030 FAX 713-512-2234

For the purpose of: ✔ medical care_____insurance_____attorney_____other _____ Ph. 713-486-6844

Please release the following:

____Entire Record **OR**

✔ Office Notes ✔ X-Ray/Imaging Reports-All Dates
✔ EMG Reports ✔ X-Ray Films- All Dates
____Lab Results-from(date)___/___/___to (date)___/___/___Other (Specify)_____
✔ All encounter notes, operative notes, test results, arthroscopy photos and consult notes

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

✔ ***Yes**, I consent to the release of this information.* ___ ***No**, I do not consent to the release of this information.*

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date: _____.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the privacy officer for Texas Orthopaedic Associates, L.L.P.

_____ _____
Signature of Patient or Legal Representative ***Date***

_____ _____
Relationship to Patient (If Legal Representative) ***Witness***

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Texas Orthopaedic Associates, L.L.P. liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative ***Date***

_____ _____
Relationship to Patient (If Legal Representative) ***Witness***

8210 Walnut Hill Lane, Ste.130
Dallas, Tx. 75231
214-750-1207
214-750-8504 fax

7115 Greenville Ave. Ste 310
Dallas, Tx. 75231
214-265-3200
214-265-3285 fax

6020 W. Parker Rd., Ste. 240
Plano, Tx. 75093
972-378-1438
972- 378-1432

8081 Walnut Hill Ln., Ste.1000
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214-239-0993
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