AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT YOU WISH TO HAVE RECORDS TRANSFERRED

PATIENT NAME: ____DOB_________________________
NEW OR CURRENT ADDRESS: ____
PHONE NUMBER: _________________________

PLEASE SELECT WHERE YOU WISH TO HAVE THE RECORD(S) TRANSFERRED TO

[ ] I AUTHORIZE THE MEDICAL RECORDS TO BE RELEASED TO: Hays Foot and Ankle Surgical Associates, PLLC PLEASE FAX RECORDS TO THE ADDRESS OR NUMBER LISTED BELOW.

FROM: ____
ADDRESS: ____
CITY/STATE/ZIP: ____
PHONE: ___________________________ FAX: ___________________________

[ ] I AUTHORIZE Hays Foot and Ankle Surgical Associates, PLLC TO RELEASE MEDICAL RECORDS TO:
NAME:
____
ADDRESS: ____
CITY/STATE/ZIP: ____
PHONE: _______________________________________
FAX: ____

INFORMATION TO BE DISCLOSED

MARK THE ITEMS BELOW THAT YOU WANT DISCLOSED

[ ] **ALL** HEALTH INFORMATION
[ ] **MEDICAL SUMMARY**/ OR SPECIFIC INFORMATION MARKED BELOW
[ ] PROGRESS NOTES FROM _______________________ TO________________________ [ ] ALL DATES
[ ] HISTORY & PHYSICAL EXAM [ ] PROBLEM LIST
[ ] MEDICATION RECORD/LIST [ ] SPECIALISTS/CONSULT REPORTS
[ ] XRAY/DIAGNOSTIC REPORTS [ ] LABORATORY TEST REPORTS [ ] OTHER (SPECIFY) ____

REASON FOR DISCLOSURE (CHOOSE ONLY ONE OPTION):
[ ] TRANSFER OF CARE [ ] TREATMENT/CONTINUED PATIENT CARE [ ] PERSONAL USE OR REVIEW ($35 CHARGE) [ ] BILLING OR CLAIMS
[ ] ATTORNEY/LEGAL [ ] INSURANCE [ ] OTHER __________________________

SIGNATURE AUTHORIZATION: I HAVE READ THIS FORM AND AGREE TO THE USES AND DISCLOSURES OF THE PROTECTED HEALTH INFORMATION (PHI)
ABOVE. THIS AUTHORIZATION WILL LAST FOR 1 YEAR FROM DATE OF SIGNATURE. I MAY REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE UPON THIS AUTHORIZATION.

____ ______________________________________
SIGNATURE OF INDIVIDUAL OR LEGAL AUTHORIZED REPRESENTITIVE PRINTED NAME OF REPRESENTATIVE DATE

RELATIONSHIP TO INDIVIDUAL: [ ] PARENT OF MINOR [ ] LEGAL GUARDIAN [ ] SELF [ ] OTHER_____________________

IN ACCORDANCE WITH STATE LAW AND REGULATORY AGENCY REQUIREMENTS, THE HEALTH RECORD IS THE PROPERTY **Hays Foot and Ankle Surgical Associates, PLLC**
. HIPPA AND TEXAS HEALTH & SAFETY CODE ᵝ181.001 MUST
OBTAIN A SIGNED AUTHORIZATION FROM THE INDIVIDUAL OR LEGALLY AUTHORIZED REPRESENTATIVE TO ELECTRONICALLY DISCLOSE THAT INDIVIDUAL'S PROTECTED HEALTH INFORMATION. AUTHORIZATION IS NOT REQUIRED FOR DISCLOSURE RELATED TO TREATMENT, PAYMENT, HEALTHCARE OPERATIONS, PERFORMING INSURANCE OR HEALTH MAINTENANCE ORGANIZTION FUNCTION, OR AS MAY BE OTHERWISE AUTHORIZED BY LAW