



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 REPRESENTATIVE

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 §181.001 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 ORGANIZATION FUNCTION, OR AS MAY BE OTHERWISE AUTHORIZED BY LAW