MEDICAL and SURGICAL CLINIC of IRVING

2021 N. MacArthur Blvd. Suite 150
Irving, TX. 75061

Authorization to Release Medical Records

Patient Name_____ Date of Birth_____

Social Security Number ____ ____ ____ - ____ ____ - ____ ____ ____ ____ Day Time Phone # _____

RECORDS RELEASED FROM: I authorize the use or disclosure of the above named individual's health information as described below. The following individual(s) or organization(s) are authorized to release information:

_____
Doctor's name or facility requesting records from

_____
Complete address of doctor or facility City State Zip

SEND RECORDS TO: The information identified above may be used by or disclosed (released) to the following individual(s) or organization(s):

_____
Doctor's Name or facility mailing records to

_____
Complete address of doctor or facility City State Zip

The type of information to be used or disclosed is as follows (check appropriate boxes):

[] problem list [] medication list [] list of allergies [] immunization records [] most recent date
[] lab results (describe the dates or types of lab tests you would like disclosed):_____
[] x-ray & imaging reports (please describe the dates or types of x-rays) _____
[] entire record [] other (please describe):_____

This information for which I'm authorizing disclosure will be used for the following purpose:

[] my personal records [] sharing with other health care providers [] other (please describe) _____

Important Information and Disclosures
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.

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 send my written revocation to Attn: Privacy Officer, MSCI, 2021 N. MacArthur Blvd., Suite 150, Irving, TX. 75061. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the laws provide my insurer with the right to contest a claim under my policy.

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I also understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Fees
Copies of records are subject to a **minimum** charge of $25.00 and prepayment is required before records are copied. **Mail payment to: Attn: HIM Department, Medical and Surgical Clinic of Irving, 2021 N. MacArthur Blvd., Suite 150, Irving, TX. 75061.**

Contact Information / Fax Number
If you have any questions you may contact the HIM Department at (972) 253-2562. We will accept this request in person, by mail to the above address or by faxing it to (972) 253-2535. However we will not accept this authorization by e-mail.

_____
Signature of patient or legal representative / Date

This authorization will expire (insert date or event):_____. If I fail to specify an expiration date or event, this authorization will expire in six months from the date on which it was signed.