

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____ SS#: _____
Address: _____

I authorize the following individual or organization(those you want the office to have permission to speak with about your care) to disclose the above named health information:

_____ Address: _____

This information may be disclosed to and used by the following individual: Dr. Gerhard Maale/ Dr. Jorge Casas M.D.
Address: 8230 Walnut Hill Lane #514 Dallas, TX 75231 Ph# 214-691-9777 fax 214-691-1123

Please release the following Information: _____ Entire Record OR:
_____ List of Allergies _____ X-rays/Imaging Reports from Date _____ to Date _____
_____ Progress Notes _____ X-ray Films
_____ History and Physical _____ Lab Results from Date _____ to Date _____
_____ Medication List _____ Other Reports (Specify) _____

In accordance with Texas State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that the information in my health record may include information relating to sexually transmitted diseases, 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, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

I understand that I have the 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 organization releasing information. 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 or may not be protected by federal confidentiality rules.

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 DFW Sarcoma Group/Dr. Jorge Casas-Ganem, M.D. 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