

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____, HEREBY AUTHORIZE,

Name of physician, hospital, insurance co., or self

Address

Telephone number/ fax number

TO RELEASE **ALL MY** MEDICAL RECORDS (PROTECTED HEALTH INFORMATION) TO:

DR. JOSEPH K. LEVENO
1600 COIT ROAD, SUITE 102
PLANO, TEXAS 75075
(972) 596-5821
(972) 596-5634 FAX NUMBER

THIS PROTECTED HEALTH INFORMATION IS NEEDED FOR:

Transferring care _____ Medical care by another specialist _____ School _____ Life Insurance _____
Military _____ Disability _____ Health insurance _____ other _____

I understand that the specific information to be released may include, but not limited to:

-history-diagnosis -HIV and AIDS -Drug or alcohol abuse -Mental illness -communicable disease

THIS AUTHORIZATION SHALL BE IN FORCE AND EFFECTIVE UNTIL 90 days after date signed, AT WHICH TIME THIS AUTHORIZATION TO USE OR DISCLOSE THIS PROTECTED HEALTH INFORMATION EXPIRES.

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION, IN WRITING AT ANY AND THAT A REVOCATION IS NOT EFFECTIVE TO THE EXTENT THAT DR. JOSEPH K. LEVENO HAS RELIED ON THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION.

I UNDERSTAND THAT INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE LAW.

DR. JOSEPH K. LEVENO WILL NOT CONDITION MY TREATMENT, PAYMENT, OR ELIGIBILITY FOR BENEFITS WHETHER I PROVIDE AUTHORIZATION FOR THE REQUESTED USE OF DISCLOSURE.

I UNDERSTAND THAT I HAVE THE RIGHT TO:

- RECEIVE A COPY OF THE PROTECTED HEALTH INFORMATION TO BE USED OR DISCLOSED AS PERMITTED UNDER FEDERAL LAW (OR STATE LAW TO THE EXTENT THE STATE LAW PROVIDES GREATER ACCESS RIGHTS.)
- REFUSE TO SIGN THIS AUTHORIZATION.

(The use or disclosure requested under this authorization will result in direct or indirect remuneration to the office of Dr. Joseph K. Leveno, from a third party.)

Signature of patient or parent or legal guardian

Date

Name of patient or personal representative

Description of personal representative's authority