Texas Healthcare, P.L.L.C.
Darien Bradford, MD
515 W. Mayfield Rd. Suite 404
Arlington, TX 76014
817-465-5311 Fax: 817-465-8569

REQUEST FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Please Print

I, ____/_____/____
Patient's Name Date of Birth SS#

____
Street Address City State Zip

do hereby authorize the use and/or disclosure of my protected health information (PHI).

AUTORIZED ENTITY

I request to have information released ☐ **from** or ☐ **to** the following entity: (check one)

____
Name

____
Street Address City State Zip

____________________________ ____________________________
Phone Fax

AUTHORIZED PROTECTED HEALTH INFORMATION

- ☐ Complete Record
- ☐ Records of care from _______________ to ______________________
- ☐ Records of regarding condtion(s):____
- ☐ Confer with designated person(s) orally about information in my medical records
- ☐ Other/ Specify: ____

I understand that the release of medical records may involve making available to myself or to others information of a personal nature. Issues with regard to personal use of cigarettes, alcohol, and other drugs a well as possible exposure to infectious disease may be part of the medical record.

HIV/ AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.

☐ **YES** ☐ **NO**

PURPOSE OF DISCLOSURE:

☐ Medical Care ☐ Employer ☐ Attorney
☐ Insurance ☐ Other

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations. I hereby acknowledge that this consent is truly voluntary and valid until revoke this consent at any time, in writing, except to the extent that action based on this consent has been taken. I further understand that this authorization will expire in 180 days from the date of signature unless otherwise specified:_______________.
Expiration Date

______________________________________ ______________________________________
Signature of Patient or Legal Guardian Date Signature of Witness Date