AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION

Name:_____ Date of Birth:_____/_____/_____

Address:_____

City:_____ State: _____ Zip:_____

Phone:_____ Social Sec.:_____

I _____, hereby authorize_____, to disclose
Previous Treating Physician or Facility

medical records pertaining to the above named patient to the provider listed below.

RELEASE MY MEDICAL RECORDS FROM:

Name:_____

Address:_____City/ST/Zip:_____

Telephone:_____Fax:_____

PLEASE RELEASE RECORDS TO:

ADD/ADHD Diagnostic & Treatment Center, PA
1524 Independence, Pkwy. Ste. A-1,
Plano, Texas 75075
972.943.0410 off. ~ 972.212.4270 fax

Please mail records containing more than 20 pages. Thank you!

I understand that:

This request is valid for 90 days from the date of this authorization unless other wise stated in written form. This applies to the records of the treatment received on or prior to the date of the authorization only. Any disclosure of future treatment will need additional authorization.

Authorizing the disclosure of this health information is voluntary. If I have questions about disclosure of my Health Information I can contact the authorized individual or organization making disclosure.

I may cancel this authorization at any time by submitting a written request to the Privacy Officer: Amy Chuang, Office Manager, except where a disclosure has already been made in reliance on my prior authorization. I understand that the revocation will not apply to information that has already been released in response to this authorization.

There may be a charge for the requested records from the physician's office releasing the records.

Please release a copy of all my medical records, including but not limited to, progress notes, operative notes, laboratory results and diagnostic tests. I understand 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 requester may not further use or disclose medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

A photocopy of this authorization shall be considered as valid as the original.

Reason for Release: ___ Primary Care Physician's Review ___ Transferring Care ___ Other

REQUIRED:

_____ _____ _____
Date: Signature of Patient Relationship to Patient