

Authorization for Use and Disclosure of Protected Health Information Medical Records Release Form

Darrell Parsons, M.D., P.A.
318 North Alleghaney, Suite 100
Odessa, TX 79761
432-640-2929 (Office)
432-640-2379 (Fax)

Patient's Name: _____ Date of Birth: _____

Address: _____

Social Security #: _____ - _____ - _____ Telephone #: (_____) _____ - _____

THIS INFORMATION IS TO BE DELIVERED BY: MAIL PICK-UP FAX

From Doctor or Organization:

From: _____

City, State, Zip

Phone: (_____) _____ - _____

Fax: (_____) _____ - _____

Destination of Medical Records:

To: Darrell Parsons, M.D., P.A.

318 N. Alleghaney Ave., STE 100
Odessa, Texas 79761

Phone: 432-640-2929

Fax: 432-640-2379

Please check type of information to be released:

<input type="checkbox"/> Eye Exam Report	<input type="checkbox"/> All Records from <u>Last Visit Only</u>	<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> EGD, Colonoscopy and Biopsy	<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Pathology Reports
<input type="checkbox"/> Recent Laboratory Test Results	<input type="checkbox"/> X-Ray Reports:	<input type="checkbox"/> X-Ray Films/Images
<input type="checkbox"/> Heart Catheterization Report	<input type="checkbox"/> Echocardiogram	<input type="checkbox"/> Stress Test Report
<input type="checkbox"/> Other (Specify):		

Purpose of Request:

<input type="checkbox"/> Treatment or Consultation	<input type="checkbox"/> Patient Request	<input type="checkbox"/> Billing or Claims Payment
<input type="checkbox"/> Other (Specify):		
Date of Appointment:		

Drug and/or Alcohol, and/or Psychiatric, and/or HIV/AIDS Records Release understand that the requested information may contain reference to or results of HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information. I authorize the release of such confidential information to the indicated party, unless prohibited in my instructions above.

Time Limit & Right to Revoke Authorization Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the office of Darrell Parsons, M.D., P.A., 318 N. Alleghaney Ave., Odessa TX 79761. Unless revoked, this authorization will expire 180 days from date of signature.

Re-disclosure understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative(Power of Attorney) who may Request Disclosure understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can view or receive a copy of the protected health information to be used or disclosed. **I authorize the office of Darrell Parsons, M.D., P.A. to use and disclose the protected health information specified above.**

Signature: _____ Date: _____

Authority to Sign if not Patient: _____

Witness: _____ Date: _____

Identity of Requester verified via: Matching Signature Other: _____