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: _____

_____

City **State** **Zip**

Phone: (_____) _____- _____

Fax: (_____) _____- _____

Please check type of information to be released:

☐ **Eye Exam Report**	☐ **All Records from Last Visit Only**	☐ **Discharge Summary**
☐ **EGD, Colonoscopy and Biopsy**	☐ **Consultation Reports**	☐ **Pathology Reports**
☐ **Recent Laboratory Test Results**	☐ **X-Ray Reports:**	☐ **X-Ray Films/Images**
☐ **Heart Catheterization Report**	☐ **Echocardiogram**	☐ **Stress Test Report**
☐ **Other (Specify):**		

Purpose of Request:

☐ **Treatment or Consultation**	☐ **Patient Request**	☐ **Billing or Claims Payment**
☐ **Other (Specify):**		
Date of Appointment:		

Drug and/or Alcohol, and/or Psychiatric, and/or HIV/AIDS Records Release I 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 I 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 I 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:** _____