

# Authorization for Disclosure of Confidential Information

Physician, Hospital, Clinic: \_\_\_\_\_ Address \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

I hereby authorize the above physicians, hospital or clinic to disclose my individual identifiable health information as described below including but not limited to information concerning communicable disease such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any such related information. I understand that if the recipient authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal and state privacy regulations.

Date: \_\_\_\_\_  
Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Social Security #: \_\_\_\_\_

Description of information to be released: (check all that apply)

<input type="checkbox"/> Health history (DOS _____)	<input type="checkbox"/> Clinician/Nurse Notes (DOS _____)	<input type="checkbox"/> Immunization Records (DOS _____)
<input type="checkbox"/> Lab Report(s) (DOS _____)	<input type="checkbox"/> Prenatal Record & Labs (DOS _____)	<input type="checkbox"/> Progress Notes (DOS _____)
<input type="checkbox"/> X-Ray report(s) (DOS _____)	<input type="checkbox"/> Research (DOS _____)	<input type="checkbox"/> Sonogram Reports (DOS _____)
<input type="checkbox"/> C-Section Op-Report (DOS _____)	<input type="checkbox"/> Pap Report (DOS _____)	<input type="checkbox"/> Other Specify: _____

The health information described herein shall be released to:

**Jose F. De Leon, M.D.**  
**1330 Prudential Dr. Suite 100**  
**Dallas, Texas 75235**  
**Telephone: 214-879-3505**  
**Fax: 214-879-3507**

Purpose of Disclosure: \_\_\_\_\_ Continuation of Care

Other: \_\_\_\_\_

I understand that this authorization will expire 180 days from the date of this authorization unless otherwise specified, \_\_\_\_\_, whichever occurs first  
Expiration event/date

I further understand that I may revoke this authorization at any time by notifying the above physician, hospital or hospital in writing at the corresponding address. I also understand that the written revocation must be dated with a date that is later than the date on the authorization and signed. The revocation will not affect any actions taken before the receipt of the written revocation.

PROHIBITION OF REDEISCLOSURE: This information is being disclosed to us from records whose confidentiality may be protected by federal law. Federal regulation prohibits us from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A copy of fax transmission of the original is as valid as the original.

This form has been read to me and I understand its meaning \_\_\_\_\_  
Initials

\_\_\_\_\_  
Signature of patient or patient's representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient's representative

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Witness