DALLAS FAMILY PSYCHIATRY

Authorization to Release Confidential Information

Patient Name: _____ D.O.B. _____

Full Address: _____City _____ State _____ ZIP _____

I authorize : (enter the information whom we are requesting from)

_____

Ph: _____ Fax: _____

To release copies of my medical records to:

Dallas Family Psychiatry LLC

3701 W Northwest Hwy, Building 1, Suite 189 Dallas, TX 75220

PH: Tel: 214-817-4616 | Fax: 800-883-1537

I authorize release of information of the following portions of my medical record:

____ Hospital Initial Intake ____ Discharge Summary _____ Medication List

____ Last Two Encounters _____Lab Results/X-Rays ____Medication History

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless, otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

Patient Signature: _____ Date: _____

Parent or Guardian: _____ Date: _____

NOTICE: The information has been disclosed to you from records whose confidentiality has been protected by federal and state law.