# Authorization for Release of Dr. Anne Medical Records

Part 1 of 2

Dr. Anne! Modern Parenting, Classic Healthcare.
www.DrAnneMD.com

## Parent or Guardian Information

Last Name | First Name | MI

Relationship to Patients Listed Below

## Patient Information

| First Name | Last Name | MI | DOB |
|---|---|---|---|
| | | | / / |
| | | | / / |
| | | | / / |
| | | | / / |
| | | | / / |
| | | | / / |

For the patients listed above, I hereby **authorize the release of the following records**:

- ☐ complete medical record
- ☐ immunization record
- ☐ drug, alcohol, or substance abuse records
- ☐ mental health records (except psychotherapy notes)
- ☐ HIV/AIDS information (including HIV/AIDS test results)
- ☐ genetic information (including genetic test results)
- ☐ other records listed below

Initial:_____
Initial:_____
Initial:_____
Initial:_____
Initial:_____

You must initial for these records.

_____

_____

_____

For the patients listed above, I authorize release of the above records for the following **reasons**:

- ☐ treatment or continuing medical care
- ☐ school
- ☐ billing or claims
- ☐ legal purposes
- ☐ personal use
- ☐ insurance
- ☐ disability determination
- ☐ other reasons stated below

_____

_____

_____

Part 2 →

# Authorization for Release of Dr. Anne Medical Records

Part 2 of 2

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For the patients and records listed above, **send my records**:


**from:** Dr. Anne Georgulas
150 S. Denton Tap Rd., Suite 116
Coppell, TX 75019

**tel**: 972–304–0091

**fax**: 972–393–0959


**to:** _____

_____

_____

tel: _____

fax: _____

I understand:

This authorization is voluntary. Treatment or payment will not be conditioned upon my signing of this authorization form.

This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: Month _____ Day_____ Year_____.

That I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

This authorization may include disclosure of information relating to DRUG, ALCOHOL and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION, except psychotherapy notes, CONFIDENTIAL HIV/AIDS-RELATED INFORMATION, and GENETIC INFORMATION only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signature _____ Date _____