EYE ASSOCIATES OF TEXAS

SHAGUN DHALIWAL, MD
EyeATX.com
P: 972-691-3937 • F: 972-691-3939

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTHCARE INFORMATION

Patient Name (Please Print) Guardian or Authorized Party Name Date of Birth

I authorize the use and disclosure of my health information as described below:

□ Complete Records □ Op Reports □ History and Physical □ Progress Notes
□ Hospital Records □ Diagnostic Imaging □ Lab Reports □ Other:_____
□ Records relating to treatment dates from:_____ to:_____

□ I give my healthcare provider permission to discuss protected health information with _____ (Name of Individual) Information to be released:

□ from □ to

_____
Name

_____
Address

_____

_____
Phone

_____
Fax

□ from **X** to

Eye Associates of Texas, PLLC
4900 Long Prairie Rd Suite 400
Flower Mound, TX 75028
T: 972-691-3937 F: 972-691-3939

Form in which records are to be released:

□ Paper Copies □ Mail □ Fax □ Pick up by patient

*IF RECORDS CONTAIN MORE THAN 25 PAGES PLEASE MAIL

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage. I understand that uses and disclosures already

EYE ASSOCIATES
OF TEXAS

SHAGUN DHALIWAL, MD
EyeATX.com
P: 972-691-3937 • F: 972-691-3939

made based upon my original permission cannot be taken back. I understand that the medical records to be released may contain information related to HIV status, AIDS, Sexually Transmitted Diseases, alcohol, or mental health services, and I hereby authorize the release of the information. To revoke this authorization, I must do so in writing and without my express revocation; this consent will automatically expire in a year from today's date. I understand that it is possible that information used or disclosed with my permission may be re- disclosed by the recipient and no longer protected by the federal Privacy Standards.

FEE SCHEDULE: State and federal laws specify a reasonable fee may be charged to offset the cost associated with the reproducing and forwarding of medical records. I understand that Eye Associates of Texas, PLLC may not condition treatment on my signing this authorization and that I have a right to refuse to sign this authorization.

_____ _____

Signature of Patient or Guardian Date

A fax copy or photocopy of this consent shall be as valid as original. If this authorization is signed by a patient's personal representative, the representative authority is based on .
(Parent, Law, Court order, POA, etc.)