INTERNAL MEDICINE ASSOCIATES OF TEXAS

7777 Forest Lane, Suite C-650, Dallas, Texas 75230, Phone: 972-566-8899, Fax: 972-566-5775

AUTHORIZATION FOR MEDICAL RECORDS

I hereby authorize: _____

Phone: _____Fax: _____

to disclose my individually identifiable health information as described below, which may include information concerning communicable disease such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

_____

Print Patient Name **Date of Birth** **Social Security Number**

Description of information to be released:

_____

_____

Purpose of the use and/or disclosure: **CONTINUATION/CO-ORDINATION OF CARE**

The health information described herein shall be released to:

Internal Medicine Associates of Texas
7777 Forest Lane, Suite C-650
Dallas, TX 75230
Phone: 972-566-8899 Fax: 972-566-5775

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

_____ _____

Signature of Patient Date