DENTON
HAND & ORTHOPEDICS

MEDICAL RECORDS RELEASE OF CONFIDENTIAL HEALTH INFORMATION

Name of Patient _____

Patient (Guardian) Phone #_____ Patient DOB:_____

Other Names Used by Patient:_____

Name or Physician or Facility that Records are being requested from:

_____

_____

I, the undersigned, authorize the release of the protected health information specified below from the medical record(s) of the above-named patient to:

Denton Hand & Orthopedics, PA
2401 W Oak St Suite 102
Denton, TX 76201
Fax: 940-535-7326

Please mail, fax, or email the requested information to my medical provider listed above the following:

INFORMATION TO BE RELEASED OR ACCESSED:

❑ All records in my file

Or Just Specific Information:

❑ Operative/Procedure Reports
❑ Radiology Reports
❑ Lab/Pathology Reports
❑ Behavioral Health
❑ Consultation Report
❑ History & Physical
❑ Clinic Notes
❑ Radiology Images
❑ Emergency Room Record
❑ Face Sheet
❑ Immunizations

❑ Other or specifically:

_____

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Your rights regarding your health information:

- You have the right to inspect a copy of the protected health information to be used or disclosed
- Your records are confidential and cannot be disclosed without your written authorization, except when otherwise permitted by law.
- Your specified information may include, but is not limited to: history, diagnosis and or treatment of drug or alcohol abuse, mental illness, or communicable disease including Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS).
- You may refuse to sign this authorization
- You may request a copy of this signed authorization

Unless revoked earlier or otherwise indicated, this authorization will expire (180 days) from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Patient (Guardian) signature: _____

Printed Name: _____

Social Security #: _____ Birth Date: _____

This authorization has been revoked *(date)*: _____

Patient signature: _____

Printed Name: _____