

RELEASE OF PATIENT INFORMATION

I hereby authorize Brent Belvin, M.D. the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Patient Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Phone Number: \_\_\_\_\_ DOB: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Check specific item(s) to be released:

All Records\*  Operative Notes  Abstract/Summary  Radiology Reports  Lab/Path Records

Progress Notes  Billing Records  Other: \_\_\_\_\_

Radiology Films (Duplicated films are on CD and not actual film.)

\*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

The purpose of this disclosure: \_\_\_\_\_

Please send the records listed above to:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

• I understand that I may revoke this authorization at any time by written notification to the providing organization and if I do, it will not have any effect on any actions they took before they received the revocation.

• I understand that there may be a fee for a copy of this information.

• I understand that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information.

\_\_\_\_\_  
Signature of patient or patient's representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient's representative

\_\_\_\_\_  
Relationship to patient

1101 Raintree Circle, Suite 240

Allen, TX 75013

OFFICE: 214-383-9270 Fax: 214-383-9271