

LUBBOCK SURGICAL ASSOCIATES, L.L.P. AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____ Medical Record # _____

Date of Birth _____ Social Security _____

I authorize the following individual or organization to disclose the above named individual's health information:

_____ Address: _____

This information may be disclosed TO and used by the following individual or organization:

Lubbock Surgical Associates, L.L.P. Ted Allen, MD Derick Haggard, MD David Mangold, MD
3611 22nd Place Sammy Rivas, MD Richard Rosen, MD Tim West, MD
Lubbock, TX 79410 Gerald Woolam, MD

For the purpose of _____

Please release the following:

_____ Problem List _____ X-Ray/Imaging Reports - from (date) _____ to (date) _____
_____ Progress Notes _____ XC-Ray Films
_____ History/Physical Exam _____ Laboratory Results - from (date) _____ to (date) _____
_____ Medication List _____ EKG Reports
_____ Immunization Record _____ Other Diagnostic Reports (Specify) _____
_____ List of Allergies _____ Other (Specify) _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services, and treatment for alcohol and drug abuse.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosures of my health information, I can contact Allison Mooney at 806.771.2222.

Signature of Patient or Legal Representative _____

Date _____

Relationship to Patient (If Legal Representative) _____

Witness _____

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Lubbock Surgical Associates, L.L.P. liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of Patient or Legal Representative _____

Date _____

Relationship to Patient (If Legal Representative) _____

Witness _____