KING FAMILY MEDICAL, PLLC
5750 Bunker Hill Road – Garland, Texas 75048 – Tel: 972 675-5300 – Fax: 972 675 5301

AUTHORIZATION FOR RELEASE OF PATIENT'S PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME: _____ DOB: _____

ADDRESS: _____ PHONE: _____

CITY/STATE/ZIP: _____

This information is to be release:

FROM		**TO**	
PERSON/FACILITY:	_____	PERSON/FACILITY:	_____
ADDRESS:	_____	ADDRESS:	_____
CITY/STATE/ZIP:	_____	CITY/STATE/ZIP:	_____
PHONE:	_____	PHONE:	_____
FAX:	_____	FAX:	_____

INFORMATION TO BE DISCLOSED:

- ❑ Copy of all health records. ❑ Billing Records.
- ❑ SPECIFIC RECORDS:
  - Laboratory Tests____ X-Ray Reports____
  - Progress Notes____ Other_____

THE PURPOSE OF THIS DISCLOSURE IS FOR:

- ❑ Continuance of Medical care.
- ❑ Attorney
- ❑ Insurance
- ❑ Other:_____

❑ Records to be faxed or electronically transmitted?

I understand that the information released as a result of this Authorization may be subject to re-disclosure and no longer protected by federal or state laws applying to medical information release.

I understand that there may be a fee for copying of my medical records if it is to be used for other than continuance of healthcare with another provider.

I understand that this Authorization may be revoked in writing at any time. I understand that revocation will apply only to releases of information made after the date of my revocation.

Unless otherwise indicated, this authorization will expire twelve (12) months from the date of signature. A photocopy of this authorization will be considered as valid as the original. I understand that I will be provided a copy of this Authorization upon request.

I understand and agree that my medical record will be maintained in an electronic medical record (EMR) format and that records may be transmitted electronically via fax, E-mail, Internet, or data transfer system.

_____ _____ _____

Signature of Patient/Legally Authorized Representative | Relationship | Date