AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Name of Patient: ____Phone Number:____________________________

Other Names Used: ____________________Date of Birth: ___________Social Security #: XXX -_______ - ________

Records Released From (Facility/Doctor):____

I, the undersigned, authorize the release of medical record information and/or protected health information of the patient listed above to the following facility:

The Lung and Sleep Center of North Texas – Dr. Ranjit Nair

7505 Glenview Drive, Suite G

North Richland Hills, TX 76180

T: 817-284-9225 F: 817-590-0079 E: drnair@lungsleeptexas.com

Purpose: ____

Date(s) of Treatment: ____

Information To Be Released Or Accessed: (check box)

- ☐ History & Physical Consultation Report
- ☐ Ordered Lab/Imaging/Pathology/Procedures
- ☐ Other ____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.

I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing law.

Patient Name (print) ____Date of Birth __________

Signature of Patient/Representative ____Date _________________

Printed Name of Patient's Representative (if applicable) ____