DIABETES AND THYROID CENTER OF FORT WORTH

Darren Lackan, MD, PA, FACE, ECNU Chris Bajaj, DO, PA, FACE, ECNU
Anjanette Tan, MD, FACE, ECNU Sara Matani, MD

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize:

Name: _____

Address: _____

Phone: _____ Fax: _____

to release healthcare information of the patient named above to the Diabetes and Thyroid Center of Fort Worth

This request and authorization applies to:

- ☐ Healthcare information relating to the following treatment, condition, or dates: _____
- ☐ All Medical Records
- ☐ Other _____

The health information described herein should be released to: (Check all that apply)

☐ Hospital ☐ Physician ☐ Insurance Company ☐ Attorney ☐ Patient ☐ Other

Method of delivery: (Please check one)

- ☐ Mail
- ☐ Fax
- ☐ Pick up records
- ☐ Other _____

I hereby authorize Diabetes and thyroid Center of Fort Worth to disclose my individually identifiable health information as described below, which may include information concerning communicable disease such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental illness, chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I further understand that I may revoke this authorization at any time by notifying this practice in writing at the address listed. I also understand that the written revocation must be signed and dated with a date that I later than the date on this authorization.

Patient Signature: _____ Date Signed: _____

Patient Phone Number: _____