Authorization for Use or Disclosure of Protected Health Information

Pt. Name: _____
SS#_____ DOB: _____
Daytime Phone#: _____ Evening Phone #:_____
Address:_____
City: _____ State: _____ Zip Code:_____

I hereby authorize _____ ____to use or disclose my protected health information as indicated below to:

Name: ___Candis Lovelace MD, FACS_____
Phone#: __817-380-1087_____ Fax #:__817-380-1088_____
Address:_ 4400 Heritage Trace Pkwy Suite 200_____
City:_____Fort Worth__ State:____TX_____ Zip Code:_____76244_____

Information to be released:

From & To Dates: _____

_____ Copy of complete records

_____ Information related to HIV testing results

_____ History and Physical/Consultation reports

_____ Laboratory, Xrays, PFT, Echo, Angio, OP reports

_____ Other _____

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

_____ Substance Abuse (including alcohol/drug abuse
_____ Mental Health
_____ Psychotherapy Notes
_____ HIV related information (including AIDS related testing)

_____ _____
Signature of Patient or Legal Guardian Date

Purpose of Disclosure:

_____Changing physician
_____Continuing Care
_____At my (patient) request
_____Workers' Compensation
Other: _____

_____ Second Opinion
_____ Legal
_____ Insurance
_____ School

1. I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying Travis Lovelace, Privacy Officer at the address indicated below in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
   New Leaf Plastic and Reconstructive Surgery
   4400 Heritage Trace Parkway Suite 200
   Fort Worth TX 76244
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specialty protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that I will get a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

Signature: _____ Relationship: _____Date: _____
Patient or representative

Witness: _____ Date: _____