PERMISSION TO SHARE PATIENT HEALTH INFORMATION

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Phone Number: ( )

Address: _____

City: _____ State: Zip:

FACILITY

Please check the current location of the records you want shared:

☐ Primary Care Associates of Texas

☐ Other: _____

RECIPIENT

I authorize Primary Care Associates of Texas to share my health information with:

Name of Person/Entity: Fort Worth Primary Care; Morvarid Rezaie, DO

Title (Physician, Attorney, etc.): Physician Phone Number: (817) 243-7995

Street Address: 800 8th Ave, Suite 616

City: Fort Worth State: TX Zip: 76104

Purpose of Disclosure:

☐ Medical Care ☐ Insurance ☐ Legal ☐ Transferring to New Provider ☐ Other (specify): _____

HEALTH INFORMATION TO BE SHARED

Copies of my health information within the following dates: _____ **to** _____

☐ **Abstract *OR* check only those documents needed:**

☐ Discharge Summary ☐ Emergency Department Reports ☐ Immunizations

☐ Inpatient Progress Notes ☐ Laboratory/Pathology Reports ☐ Operative Reports

☐ Outpatient Visit (Office) Notes ☐ School Physical Forms ☐ X-Ray Reports ☐ X-Ray Films

☐ Other_____ ☐ Records from a specific provider: _____

Delivery Preference: ☐ Pickup ☐ Mail ☐ Patient Portal ☐ Fax (for Medical Care purposes) - Fax Number: (_____)_____

SENSITIVE HEALTH INFORMATION

The following types of information <u>will be released UNLESS</u> you place your initials in the space provided:

_____ Mental health treatment records

_____ Genetic testing

_____ HIV/AIDS test results

_____ Sexually Transmitted Disease (STD) treatment records

_____ Alcohol/drug abuse treatment records, including Dartmouth-Hitchcock Psychiatric Associates Addiction Treatment Program (DHMC-ATP)

DURATION & REVOCATION

This authorization will remain in effect for one year from the date of the signature below, unless you specify a different date here: _____ (date). You or your Personal Representative may revoke this authorization at any time by providing written notice as specified in our Notice of Privacy Practices; however, your revocation will not apply to any previously released information.

ADDITIONAL INFORMATION

I understand that:

- A fee for the cost of processing this request may be charged.
- Primary Care Associates of Texas will not condition my ability to receive healthcare services on providing or refusing to provide this authorization. The only circumstance where refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.
- Once this information is shared with the recipient you specified above, how that recipient further discloses it may no longer be protected under federal and state privacy regulations.
- Primary Care Associates of Texas may utilize a business associate/authorized agent to assist in fulfilling this request.

SIGNATURE

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Printed Name of Patient or Personal Representative **Description of Personal Representative's Authority**