Darren E. Meyer, M.D., Praveen Moolamalla, M.D.
and Ron Hanson LCSW-ACSW
1575 Heritage Drive, Suite 203
McKinney, Texas 75069
972-529-5445 Fax: 972-540-1554

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: _____

Date of Birth: _____ SS#: _____

I authorize the office of **Darren E. Meyer, M.D., Praveen Moolamalla, M.D. and Ron Hanson, LCSW-ACSW** to disclose the above named individual's health information to:

Name: _____

Phone: _____ Address: _____

Fax: _____ _____

Please release the following:

_____ Progress Notes
_____ Laboratory Results
_____ Prescription Information
_____ Coordination of care letter
_____ Psychiatric Evaluation
_____ History and Physical
_____ Discharge Summary
_____ X-Ray / MRI / CT Scan Reports

I understand that the information my health record may include information relation to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

If I fail to specify an expiration date, event or condition, THIS AUTHORIZATION WILL EXPIRE IN SIX MONTHS. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information being used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Jamie Shepard.

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold the office of Darren E. Meyer, M.D. and Praveen Moolamalla, M.D. liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Witness Signature

Prepared by (initials only) _____ Date _____