TO US

Methodist Mansfield Minimally Invasive Surgical Associates

2800 E. Broad Street, Suite 304
Mansfield, TX 76063
Ph# (817) 225-0560
Fax# (817) 225-0565

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name of Patient: _____("Patient")

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Date of Birth: _____ Age: _____ Sex: _____

Social Security Number: _____ Account Number: _____

Date of Last Visit: _____ Physician Seen: _____

1. I authorize the use or disclosure of the Patient's health information, as described below.

2. The following individual(s) or organization(s) are authorized to make the disclosure:

   Name**:** _____

   Address: _____

   Phone: _____Fax**:**_____

3. The type and amount of information to be used or disclosed is as follows: (Please Check)

   ___ Entire Health Record ___ Operative Procedures ___ Pathology Report ___ History & Physical

   ___ X-ray/Imaging Reports ___ X-ray Film ___ Echocardiogram ___ Laboratory Reports

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

5. This information may be disclosed to and used by the following individual(s) or organization(s):

   [ ] MMMISA

6. This information is being disclosed for the following purpose(s); _____

_____

7. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the Methodist Mansfield Minimally Invasive Surgical Associates at which authorization was originally submitted. I understand that the revocation will not apply to information that has already been released in response to this authorization. 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.

8. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

_____

If I fail to specify an expiration date, event, or condition, this authorization will expire six months from the date of signing.

9. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.

10. I understand that I will be given a copy of this authorization form, after signing.

11. I understand that Methodist Mansfield Minimally Invasive Surgical Associates not condition treatment on whether I sign this authorization.

_____ _____

Signature of Patient/Responsible Party or Legal Representative Date

_____ _____

If Signed by Legal Representative, Relation to Patient Date

_____ _____

Signature of Witness Date