AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

Please REQUEST medical information FROM:

Primary Care Provider:

_____

Please select location:

___ Legacy Medical Village
___ Independence Medical Village
___ McKinney Medical Village

Please SEND medical information TO:

Clinic/Physician:_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____

Fax:_____

I hereby authorize the above-mentioned provider to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above. I also understand this information may contain information relating to Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV), mental health, and alcohol and /or drug abuse.

Release and/or disclose records and information regarding:

_____	_____ - _____ - _____	_____ /_____ / _____
Name of Patient	Social Security Number	Date of Birth

_____	_____	_____	_____
Address	City	State	Zip Code

_____	_____	_____
Home	Work	Cell

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for ninety days from the date of signature if no date entered.
REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.
REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

PLEASE SPECIFY RECORDS TO BE RELEASED AND/OR DISCLOSED:
CD or electronic version is preferred.

____ Entire medical records ____ History and Physical ____ Chart Summary ____ Labs ____ Radiology ____ Pathology
____ Other (please specify) _____

I request that the health information release and/or disclosed pursuant to this authorization be used for the following purposes only:
____ Physician or Health Care Facility ____ Legal ____ Personal ____ Other (please specify) _____

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization. The copy is for me to keep. I understand that there may be a fee for preparing and furnishing this information.

_____	_____	_____
Signature of patient or legal representative	Date	Relationship if not patient

Legacy Medical Village
5425 W. Spring Creek Pkwy, Suite 200
Plano, TX 75024
T: 972-599-9600 F: 972-599-9696

Independence Medical Village
8080 Independence Pkwy, Suite 200
Plano, TX 75025
T: 972-596-9511 F: 972-867-8163

McKinney Medical Village
7300 Eldorado Pkwy, Suite 200
McKinney, TX 75070
T: 972-599-9600 F 972-599-1800