David Meduna, M.D., P.A.

HIPAA AUTHORIZATION TO RELEASE PATIENT INFORMATION

PATIENT'S NAME: _____DOB: _____SSN: _____Ph:_____

TO: _____ PH: _____ FAX: _____

ADDRESS: _____

FROM: David Meduna, MD PH: 979-764-6868 FAX: 979-485-0707

ADDRESS: 1601 Rock Prairie Road, Ste. 3100 College Station, TX 77845

PURPOSE OF DISCLOSURE (Circle):

Transfer of Care Continuity of Care Insurance Personal Use Other (please specify)_____

RECORDS TO INCLUDE:

This authorization pertains to the disclosure of records types indicated below between the following dates of service:

From: _____ To: _____ or **ALL**

RECORDS TO INCLUDE (Circle all that apply):

Progess notes Lab/Pathology Results Immunization Records Operative Reports

Imaging/radiology/mammogram Records ALL records obtained by facility. Other: _____

I acknowledge, and hereby consent to such, that the release information may contain alcohol, drug abuse, psychiatric, HIV testing results or AIDS information. _____**Initials**

EXPIRATION: This authorization shall expire 180 days from the date of signature. I understand that this authorization may be revoked by me at anytime except to the extent that action has been taken. I have the right to revoke this Authorization at any time prior to 180 days by giving the healthcare provider written notice of revocation of this Authorization. _____ **Initials**

RE-DISCLOSURE: I understand the information disclosed by this Authorization may be subject to re-disclosure by the receipient and no longer protected by the Health Insurance Portability and Accountablity Act of 1996.

I understand that:

- I have the right to refuse to sign this Authorization
- I have the right to receive a copy of this Authorization
- I have the right to inspect or copy the protected health information to be used or disclosured
- Fees/Charges will comply with all laws and regualtion applicable to release of information
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FEES FOR COPIES: When a patient requests a copy of his/her PHI for personal use, federal law permits a reasonable, cost-based fee that includes only labor for copying the PHI & cost for supplies. If the charges will exceed $25, we will inform you approximate charges prior to your request being filled.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING; INCOMPLETE FORMS WILL NOT BE PROCESSED.

I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____ _____

Signature of Patient/Parent/Guardian Date Relationship to patient