continuum
INTERNAL MEDICINE

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Authorization For Release of Health Information

PLEASE FAX BACK PATIENT RECORDS WITH COPY OF THIS PAGE AS COVER

FAX TO: 214-231-2181

Records Released From:

Continuum Internal Medicine/TDDC

Phone: (214) 623-6254

Fax: (214) 231-2181

Records Released To:

_____

○ **Mail to:** _____

_____

Phone: _____

○ **Fax:** _____

I, _____ **authorize the release of medical records for the records of:**

Patient Name: _____ **Date of Birth:** _____

Dates From: _____ **To** _____ **OR** ○ **All Records**

I understand that my express consent is required to release any health information relating to testing, diagnosis and/or treatment of alcohol or drug related medical problems. And this special consent also will apply to HIV/AIDS related diagnosis, sexually transmitted disease and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations(42 C.F.R. Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it may pertain or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith. This authorization expires ninety (90) days from the date of this signature.

_____ _____ _____

Signature of Patient or Legal Representative **Relationship to Patient** **Date**