TEXAS SPORTS REHAB

Authorization to Release Medical Records

I _____ who resides at _____

in the city of _____ in the state of _____ hereby authorize:

Name: Texas Sports Rehab
Address: 6901 Snider Plaza, Suite 100
City, State, Zip: Dallas, TX 75205

to disclose the following specific medical information by ☐ mail or ☐ fax to:

Name: _____

Address: _____

City, State, Zip: _____ Fax #: _____

from the health records of:

Name: _____

Address: _____

City, State, Zip: _____ Phone #: _____

for the purpose of: _____

My authorization extends only to those data elements/documents initialed below:

_____ Statements of charges or payments
_____ Records of visits (all visits)
_____ Record of visit for a specific date or dates. Specific dates include or are limited to: _____
_____ Initial assessment
_____ Progress notes
_____ Discharge summary
_____ All of the above
_____ Other (must be specific): _____

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as the original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available at your request.
4. Texas Sports Rehab, it's employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this authorization.
6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ _____
Patient's Name Printed Date

_____ _____
Patient's signature (Or Guardian, If a Minor) Expiration Date (If Other Than One Year)

_____
Patient's Date of Birth (For Identification Purposes Only)