

TEXAS SPORTS REHAB
Revocation of Authorization to Release Medical Records

I, _____, who resides at _____

In the city of _____ in the state of _____ hereby revokes authorization to:

Texas Sports Rehab
6901 Snider Plaza, Suite 100
Dallas, TX 75205

to disclose protected health information from the medical records of:

Name: _____

Address: _____

City, State, Zip: _____

This revocation is given freely with the understanding that:

1. Disclosures made in good faith may have already occurred in reliance upon my previously issued authorization and that this revocation cannot apply retroactively to such disclosures. I also understand that the disclosure of health information may be required by law in some instances, such as for subpoena or reporting a crime.
2. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the information I authorized previously.
3. To request protected health information in the future, a new Release of Medical Records form will be required.

Patient's Printed Name

Date

Signature of Patient (Or Guardian, If A Minor)

Date of Birth (For Identification Only)