Midland Plastic Surgery Center PA
701 N Tradewinds Blvd, Suite B
Midland, TX 79706
Office: 432-618-6772
Fax: 432-618-6775

Authorization to Disclose Protected Health Information

Patient Name: _____ Date of Birth: _____

Address: _____
Street City State Zip Code

Purpose of Request: Continuation of Care Personal Legal Insurance
(please circle)

I authorize release to: _____ Phone: ( ) _____

Name/Facility: _____ Fax Number: ( ) _____

Address: _____
Street City State Zip Code

Date of Service Range From: _____ To: _____

- ☐ Billing Records
- ☐ Clinic/Progress Notes
- ☐ Complete (All records, notes, meds, flowsheets, etc.)
- ☐ Discharge Summary
- ☐ Emergency Room Report or Operative Notes
- ☐ History and Physical
- ☐ Lab Results
- ☐ Radiology Reports
- ☐ Other: _____

1. Requests will be processed within 15 business days of receipt.
2. I authorize the release of my medical record, including photographs.
3. This authorization is voluntary, and the disclosure is made at my request.
4. If the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
5. Multiple requests are authorized if the purpose of the request remains the same.
6. I have a right to revoke this authorization at any time and if I revoke this authorization, I must do so in writing and present the written revocation to the department that I have authorized to release the information. Any revocation will not apply to information that has already been released in response to this authorization.
7. I need not sign this form to ensure health care treatment. I request this authorization to expire on _____ or 180 days from the date signed below and covers only treatment for the dates specified above. I am also aware fees, outlined below, for copy services may apply.

NOTE: Fees/charges will comply with all laws and regulations applicable to the release of information. Standard copying fees are as follows: $25.00 for the first 20 pages of the medial records and $.50 for each additional page thereafter. Additionally, an initial set of radiological films/CD-ROM can be provided at no cost to a patient for physician or facility referral. However, a fee of $5.00 per sheet of film and $7.00 per CD-ROM will be charged for additional copies.

IMPORTANT WARNING: The documents accompanying this message are intended for the use of the person or entity to which this message is addressed. These documents may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law. If you are the employee or agent responsible to deliver this information to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED.

_____ _____

Patient Signature **Date**