INTERNAL MEDICINE ASSOCIATES OF DALLAS

Joseph M. Rothstein, MD / Pratik C. Kapadia, MD / Nazish Islahi,MD

PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

*I hereby authorize: (Check the appropriate physician below)
____ **Nazish Islahi, MD** ____Joseph M. Rothstein, MD ____ Pratik C. Kapadia, MD with Internal Medicine Associates of Dallas to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.
*I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

Print Patient Name ______________________________

Date of Birth (month/day/year) ___ ___/___ ___/___ ___ ___ ___ Last 4 of Social Security Number ___ ___ ___ ___

Patient Address ______________________________

Phone Number (________) ________ - ________________

Date(s) of Service (if known) ______________________________

Description of information to be released: (Check all that apply)
____ Complete medical record- this will include all information below
____ Demographic information (Name, date of birth, address, telephone, insurance)
____ Billing records
____ Progress Notes (history & physical, physician orders, nurse notes, immunizations)
____ Test results (lab, radiology, cardiology, neurophysiology, respiratory)
____ Consultation reports (information from any other doctors)
____ Other: ______________________________

Description of the purpose of the use and / or disclosure (ex: Patient requesting disclosure, changing doctors, or for treatment):
____
____

The health information described herein shall be released to: (Check the appropriate category)
____ Hospital ____ Physician ____ Insurance Company ____ Attorney ____ Patient ____ Other

Name ______________________________

Address ______________________________

____

(Check delivery method)
____ Mail
____ Fax(less than 25 pages)
____ Pick-up Records

Phone Number (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Fax Number (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

*I understand that this authorization will expire by law 365 days from the date of this authorization unless I otherwise specify.
*I further understand that I may revoke this authorization at any time by notifying Internal Medicine Associates of Dallas in writing at 3600 Gaston Ave., Barnett Tower, Suite 1004 / Dallas, Texas 75246. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

______________________________ ____________
Signature of Patient or Patient's Representative Date

____
Printed Name of Patient's Representative

____
Relationship to Patient

--------------------**For Office Use Only**--------------------
__ Authorization added to the patient's record on ______________________________.
__ Patient has been provided with a copy of the signed authorization.