Jerry D. Vandel, M.D. & Erica Burgett, FNP-BC
2911 Medical Arts St., Bldg. 10
Austin, TX 78705

Office: 512-477-1405 Fax: 512-477-1220

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

We Will Be Requesting Records FROM: (please complete a separate form for each physician/facility)

_____

Name of Previous/Other Healthcare Provider/Physician/Facility

_____

Street Address

_____

City, State and Zip Code **Phone #** **Fax #**

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

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

☐ All medical records, meaning every page in my record (unless date range is included), including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers. **Date range:** _____ **to** _____.

☐ All physical, occupational and rehab requests, consultations and progress notes.

☐ All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myelogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports. **Date range:** _____**to** _____.

☐ All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purposes: **Continuity of Care [ ] Change of Physician(s) [ ]**

OR: _____

I understand the following:

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____ _____

Signature of Patient or Legally Authorized Representative Date | Name and Relationship of Legally Authorized Representative to Patient

_____ _____

Witness Signature | Date