Anna Rosinska M.D.
3316 Andrews Hwy
Midland, TX 79703
(432) 688-1900
www.AskDrAnna.com

Authorization to Release Protected Information (PHI)

Patient's Name: _____

SSN: _____

Date of Birth: _____

Home Phone: _____

I hereby authorize: _____
(Health Care Provider)

Address: _____
Address City State Zip

Phone: (____) _____ Fax: (____) _____

To disclose my individually identifiable health information as described below, which may include information concerning Human Immunodeficiency Virus ("HIV") or Acquired Immunodeficiency 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 hereby authorize the above-named health care provider to disclose records obtained in the course of my evaluation and/or treatment, and to send them by U.S. mail service and/or electronic facsimile to:

Dr. Anna Rosinska
3316 Andrews Hwy
Midland, TX 79703
Ph (432)-688-1900
Fax (432)-684-7049

Type of access Requested:

Medical Records: □ Entire Record □ Selection(s) of PHI as marked:

□ History & Physical
□ Discharge Summary
□ Laboratory Reports
□ Consultative Reports
□ Operative reports
□ Diagnosis & Treatment
□ Radiology Reports
□ Emergency Room
□ Physical Evaluations
□ Psychiatric Evaluations
□ Psychological Eval
□ Physical Therapy
□ Progress Notes

□ Other: _____

Dates of Service from _____ to _____

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Authorization to Release Protected Health Information (PHI)

Purpose for release or disclosure of Protected Health Information: Pursuant to TITLE 45, PART 164, SECTION 164.508© (1) (IV) of the CODE OF FEDERAL REGULATIONS. I state that the purpose of this disclosure is "at the request of the individual."

I understand that this authorization is voluntary and I may refuse to sign this authorization. I understand that the above named healthcare provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I further understand that I have a right to receive a copy of this authorization.

This authorization shall expire 365 days from the date of my signature below. I understand that I may revoke this authorization at any time by notifying the medical provider above in writing. I understand that such written revocation must be signed and must be dated later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the revocation.

It is my express intention that this authorization is given in compliance with the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA) (Public LAW 104-191); TITLE 45, PART 164, SECTION 164.508 of the CODE OF FEDERAL REGULATIONS; § 159.005 of the TEXAS MEDICAL PRACTICE ACT; §201.405 of the TEXAS OCCUPATIONS CODE; TITLE 22, PART 9, CHAPTER 165 of the TEXAS ADMINISTRATIVE CODE; and TITLE 22, PART 3, CHAPTER 80 of the TEXAS ADMINISTRATIVE CODE.

A copy or facsimile of this authorization is as valid as the original.

I have read the above, or have had it read to me, and authorize the disclosure of the Protected Health Information as stated.

_____

(*Signature of Patient / Legal Guardian or Representative**) *(Date)*

_____

(Signature of Witness *(Date)*

If signed by other than patient, indicate relationship and a description of your authority to act for patient: _____

_____

_____