Associates In Medicine Houston
4543 Post Oak Place, Suite 105
Houston, Texas 77027

Health Information Management Department

Authorization and Request for Release of Medical Records

Phone: 713-797-1087

Fax: 713-797-9814

Patient Information

Name Phone Number

Address City State Zip Code

Date of Birth Social Security Number

I hereby freely, voluntarily, and without coercion, authorize Associates In Medicine Houston or Business Associate (ScanSTAT Technologies) to release a copy of my medical records for the purpose of review and examination and further authorize Associates in Medicine Houston or Business Associate (ScanSTAT Technologies) to provide such copies as requested.

Records to be provided to:

Name Phone Number

Address City State Zip Code

The reason for disclosure is _____

No limitations placed on dates, history of illness, or diagnostic and therapeutic information, including any treatment for alcohol and drug abuse, HIV testing and / or AIDS related information unless indicated below. However, the recipient of this information may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

Dates of Service Requested _____

__ Physician Notes	__Consultations	__ Operative Report
__ Lab Studies	__ Prescriptions	__ Discharge Summary
__ Radiology Report	__ Pathology Report	__ History and Physical
__ Entire Record	Other _____	

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), the information described above may be redisclosed and no longer protected by these regulations. I understand that I may revoke this authorization in writing at any time and that if no date is given this authorization will expire in 90 days _____ (Date).

I understand that if the records are released directly to me or authorized representative there will be charges associates to the release of this information.

Patient (if not Patient then proof of legal guardian, power of attorney, authorized representative required) Date:

Witness Signature: Date: