



William A. Paruolo, M.D., P.A.
6053 Main Street Suite 225
The Colony TX 75056
972-370-2425/Fax 972-370-2591

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____ Date of Birth _____

I authorize the following organization to disclose the above named individual's health information

Name _____

Address _____ Phone or Fax _____

This information may be disclosed TO and used by the following

Name _____

Address _____ Phone or Fax _____

For the purpose of: Medical Care

Please release the following:

Immunization Record Complete Record Other Diagnostic Reports _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked this authorization will expire of the following date, event or condition _____ If I fail to specify an expiration date, event or condition this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164:524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact the privacy officer at this office.

Signature of patient or legal representative _____ Date _____

COMPLETE ONLY IF INFORMATION IS TO BE RELEASE DIRECTLY TO PATIENT:

I understand that my medical record many contain reports, test results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entry made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Willaim A. Paruolo, M.D., P.A. liable for any misinterpretation of the information tin my medical record as a result of not consulting my physician for the correct interpretation

Signature of Patient or Legal Representative _____ Relationship _____ Date _____