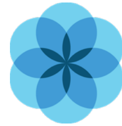

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

WHO:

Patient Name:________________________________ **Date of Birth**:___________________________________

Mobile Phone: _______________________________ **Other Phone**:___________________________________

Address: ____________________________________ **City/State/Zip**: _________________________________

Email:______________________________________

WHEN/WHAT:

Dates and Type of information to disclose:

- 3 years prior to last date seen
- Vaccine record
- Radiology, Lab, Diagnostics
- Office notes, discharge summaries
- Consult notes, Sleep Studies, Admin documents
- All of the above

Specific Information Requested: ________________

WHY:

Purpose of disclosure:

- Continuity of care
- Transfer of care
- Referral
- Other_____________________________

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

TO:

Shaya Precision Health PLLC
Tayma S. Shaya M.D. FAAFP
16605 Southwest Fwy #350
Sugar Land, TX 77479
Phone: 281-201-2230
Fax: 281-215-5092 (if <10 pages)
Email: info@shayahealth.com (if >10 pages)

FROM:

Facility Name: ____________________________
Facility Address:___________________________
City/State/Zip: ____________________________
Facility Phone: ____________________________
Facility Fax:______________________________

Please note: Facility my have an outgoing medical records fee that is charged to you
Above listed patient authorizes the above facility to make record disclosure

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I understand I may 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 outgoing facility. I understand that the revocation will not apply to information that has already been 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 on the following date, event, or condition: __1year__. 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 assure treatment. I understand that I may inspect or obtain a copy of 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 redisclosure and the information may not be protected by federal confidentiality rules. I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Signature X__________________________
Printed Name: __________________________
Date:_______________________________

If guardian/Authorized representative, please attach documentation of that relationship as well as address and phone number.