Authorization For Release Of Information

I hereby authorize _____ to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency 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 understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the release information may no longer be protected by federal and state privacy regulations.

_____	____/_____/____	_____-____-_____
Patient Name	Date of Birth	Social Security Number

Date(s) of service (if known)_____

Description of information to be released: *History and Physical, Progress notes, Discharge summary, Radiology reports, Consultation reports, Laboratory records, Medication list, Patient Summary Flow sheet.*

Description of the purpose of the use and/or disclosure:
__Continuity of care_____

The health information described herein shall be released to: ___Hospital; ***X*** Physician

E. S. Romanelli, M.D., P.A. 1141 Kinwest Parkway, Suite 100, Irving, TX 75063
or fax to 214-239-2223

I understand that this authorization will expire by law 180 days from the date of this authorization unless otherwise indicated.
I desire this authorization to be in effect until _____-_____-_____.
Expiration event/date

I further understand that I may revoke this authorization at any time by notifying E.S. Romanelli, M.D., P.A in writing at 1141 Kinwest Pkwy, Suite 100, *Irving, TX 75063* .
I also understand that the written revocation must be signed and dated with a date that is latter than the date of authorization. The revocation will not affect any action taken before receipt of written revocation.

_____	____/_____/_____
Signature of Patient or Patient Representative (If minor, please complete information below)	Date

_____
Printed name of Patient Representative

_____	or	_____
Relationship to Patient		Legal Authority (attach supporting documentation)