AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
LUBBOCK GASTROENTEROLOGY & LIVER ASSOCIATES

Patient Name: _____

Preferred Named: _____

Address: _____ City _____ State_____Zip_____

Record Number: _____ Date of Birth: _____

Phone Number: _____Alt. Phone_____

I authorize the following to disclose the individual's protected health information

I request and authorize the following entity and its employees and agents to release information relating to the diagnosis, care, and treatment of the above named patient:

[ ] Lubbock GI & Liver Associates, Dr. Sameer Islam

[ ] _____

[ ] _____

Who can receive and use the health information

[ ] Lubbock GI & Liver Associates, Dr. Sameer Islam

Records Received By:

Person/Organization: _____ ☐ Fax

Address: _____ ☐ Mail

City: _____State_____Zip_____ ☐ Pick up

Phone Number: _____ Fax Number: _____

What information can be disclosed?

Check off the appropriate item(s) and include other necessary information.

Date of service: From: _____ To: _____

☐ All health information	☐ Discharge Summary	☐ Operation Reports
☐ Past/Present Medications	☐ EKG/Cardiology Reports	☐ Diagnostic Test Results
☐ History/Physical Exam	☐ Radiology Reports & Images	☐ Progress Notes
☐ Physician's Orders	☐ Lab Results	☐ Consultation Reports
☐ Billing Information	☐ Procedure Reports	☐ Other:_____

Your initials are required to release the following information:

_____ Mental Health Records (Excluding psychotherapy note)

_____ Genetic Information (including Genetic Test Results)

_____ Drug, Alcohol, or Substance Abuse Records

_____ HIV / AIDS Test Results/Treatment

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Purpose of Discloser

This information is being released for the following purpose(s):

- ☐ Continued care by other health care providers
- ☐ Attorney
- ☐ Personal Review
- ☐ Disability Determination
- ☐ Other:_____
- ☐ Insurance
- ☐ School
- ☐ Billing Claims
- ☐ Employment

Terms of Discloser

Effective Time Period. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month_____Day_____Year_____

Right to Revoke: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under *"who can receive and use the health information."* I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

Signature Authorization: I have read this form and agree to use and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to other covered entities as provided by Texas Health & Safety Code § 181.154 (c) and/or 45 C.F.R § 164.506(a)(I). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

_____ _____

Signature of Patient or Patient Representative **Date**

_____ _____

Printed Name of Legally Authorized Representative (if applicable) **Date**

If representative, specify relationship to the individual: ☐ Parent of Minor ☐ Guardian ☐ Other_____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e,g., Tex. Fam. Code. § 32.003)

Signature x_____ _____

Signature of Minor Individual **Date**