Pleasant Ridge Internal Medicine
1806 W. Pleasant Ridge Rd.
Arlington, TX 76015

Theresa D. Stretch, MD
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AUTHORIZATION TO DISCLOSE MEDICAL/FINANCIAL INFORMATION

Patients Name:_____ Date of Birth:_____

Last 4 of Social Security #:_____

I, undersigned, hereby authorize Pleasant Ridge Internal Medicine to disclose PHI from my medical or financial record to the following person/people:

Name:_____

Relationship:_____

Type of information: (Circle One) Medical Financial Both

Name: _____

Relationship:_____

Type of information: (Circle One) Medical Financial Both

Name:_____

Relationship:_____

Type of information: (Circle One) Medical Financial Both

New federal privacy guidelines, HIPPA, prevent this office from disclosing protected health information (PHI) to anyone other than the patient. By signing this form, you are allowing us to communicate with designated individuals regarding your medical and financial records with this facility.

This authorization is given freely with the understanding that:

1. I may revoke this authorization in writing at any time, but not retroactively
2. The facility, its employees, and physicians are hereby released from any legal responsibility or liability for disclosure of the information I have authorized

Patient Signature:_____ Date:_____

THIS AUTHORIZATION EXPIRES 1 YEAR AFTER IT IS SIGNED