Pleasant Ridge Internal Medicine
1004 S. Carrier Pkwy
Grand Prairie, TX 75051

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AUTHORIZATION TO DISCLOSE MEDICAL/FINANCIAL INFORMATION

Patient's name: _____ Date of Birth: _____

Last 4 of social security #: _____

Good contact phone number: _____

Do you authorize us to leave a detailed message regarding test results, medication information, or medical information on the number provided above: YES or NO?

I, undersigned, hereby authorize Pleasant Ridge Internal Medicine to disclose PHI from my medical or financial records 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 law privacy guidelines, HIPAA, 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 understating that:

1. I may revoke this authorization in writing at any time, but not retroactively.
2. The facility, its employees, and physicians are hereby release 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