WOUND CARE and HYPERBARICS

Medical Records Release Form

Name of Patient: _____

Date of Birth: _____**Social Security Number** _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR: Continuing Medical Care

INFORMATION TO BE RELEASED OR ACCESSED:

1) History & physical Consultation Report
2) Emergency Room Record, Discharge / Death Summary
3) Operative Reports
4) Face Sheet
5) Lab/Path Reports / Diagnostic Reports / Images
6) Other: _____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

R3 Wound Care & Hyperbarics
1720 FM544, Suite 100
Lewisville, TX 75056

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnosis, and /or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire twelve (12) months from the date of my signature, unless I revoke the authorization prior to that time.

Signature: _____ **Date:** _____

Phone: 817-337-6604 Fax: 817-337-6866

WOUND CARE and HYPERBARICS

Medical Information Release Form

Patient:

Full Legal Name: _____ Date of Birth: _____Gender: M F

Home Address: _____

Information for Medical Treatment:

Name of Practice: **R3 Wound Care & Hyperbarics**

This Authorization shall be in force on _____ and remain effect until _____, I understand that I have the right to revoke this authorization, in writing, at any time except to the extent that action has been taken in reliance thereon.

Authorization to release Medical information

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of **R3 Wound Care and Hyperbarics** to release or disclose any protected health information to _____, to include all or only:

- o **Medical History** o **Insurance Records** o **Billing information**

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my Signature below. I am entitled to a copy of this authorization.

Patient or Legal Guardian's Signature: _____

Relationship to Patient: _____

Witness Signature: _____ Date: _____

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)