Authorization to Disclose (Release) Health Care Information

1. Patient Information:
   PRINT Patient Name: _____
   Birth Date _____
   Address: _____
   City, State, Zip Code: _____
   Telephone Number: _____

2. INFORMATION TO BE RELEASED TO: [ ] Check if the same as 1 above
   Organization: **Pak Medical Group**
   Address: **1762 Common Street**
   City, State, Zip: **New Braunfels, TX 78130**
   Phone: **(830)730-8580** Fax: **(830) 327-1021**

3. INFORMATION TO BE RELEASED FROM:
   Organization, physician, or provider: _____
   Address: _____
   City, State, Zip: _____
   Phone: _____ Fax: _____

4. PURPOSE OF RELEASE
   [ ]Transfer of Care [ ]Legal [ ]Insurance [ ]Specialist [ ]Personal copy [ ]Other _____

5. WHAT KIND OF INFORMATION DO YOU WANT RELEASED:
   [ ] Copies of Records
   [ ] Medical Records from ___/ ___ /___ to date: ___/___ /___
   [ ] Specific Information (please specify): _____
   [ ] Billing Records (please specify): _____
   [ ] Diagnostic Reports (please specify): _____

PATIENT AUTHORIZATION: I understand that:

a. Information released may include information regarding the testing, diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency or mental/psychiatric illness and for patients age 13-17, information regarding reproductive care. I give my specific authorization for this information to be released.

b. Generally, Pak Medical Group and any other entity covered by the Health Insurance Portability and Accountability Act of 1996, may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. If this authorization is for purposes of determining enrollment, eligibility, underwriting or risk rating prior to enrollment, not signing or revoking this authorization may impact enrollment or benefit determinations by Pak Medical Group.

c. I may revoke this authorization in writing. If I revoke my authorization, it will not affect any actions already taken based upon this authorization. Once disclosed, health care information may be subject to redisclosure by the recipient and may no longer be protected under health information privacy laws.

d. This authorization expires 90 days from the date signed OR on this date: _____

SIGNATURE: _____ DATE: ____/___/___
(Patient or Member, Guardian, or Authorized Representative).

MINOR SIGNATURE: _____ DATE: ____/___/___
(Signature of minor ages 13-17 is required to release information listed above)