RONALD L. DOTSON, MD, PA 420 EAST HIGHWAY 67 DUNCANVILLE, TEXAS 75137
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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name:____

(Please print Patient Name)

Date of Birth: ______________________ Social Security Number:____________________

I authorize the following individual or organization to disclose the above named individual's health information:

To:________________________ **Address and or fax #:**________________________

-or-

From:________________________ **Address and or fax #:**________________________

For the purpose of:____

Please release the following:

________**Entire Record** (or)

___ Problem List ___ Progress Notes __ History / Physical Exam ___ Medication List __ Immunization Record
___ List of Allergies ___ X-Ray / Imaging Reports ___ X-Ray Films ___ Laboratory Results __ EKG Reports
___ Genetic Testing Info ___ Other Diagnostic Reports ___ Other ________________________

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human Immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_________ YES, I consent to release of this information. __________ No, I do not consent to release of this information.

I understand that the information released is for specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing the information. I understand that revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurance with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date:

____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 165-524. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, **I can contact Dr. Dotson's office.**

______________________________ ______________________________
Signature of Patient or Legal Representative Date

______________________________ ______________________________
Relationship to Patient (if Legal Representative) Witness

Complete below only if information is to be released directly to patient:

*I understand that my medical record may contain reports, test results, and notes that only physicians can interpret. I understand and have been advised that I should contact my physician regarding the entries in my medical record, to prevent my misunderstanding of the information contained in these entries. I will not hold **Dr. Dotson or his staff** liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.*

______________________________ ______________________________
Signature of Patient or Legal Representative Date

______________________________ ______________________________
Relationship to Patient (if Legal Representative) Witness