AUTHORIZATION TO RELEASE MEDICAL RECORDS

The Holiner Psychiatric Group
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Joel Holiner, MD Rodolfo Molina, MD Walter Elliston, MD
Robert Freele, MD Arthur Chavason, MD Aditya Sharma, MD

_____ _____
Patient Name (please print) Date of Birth

_____ _____
Social Security Number Phone #

A copy of my initial psychiatric evaluation ***will be sent*** to my referring physician unless checked ☐ Do not send

PLEASE RELEASE COPIES OF MY MEDICAL RECORDS TO THE INDIVIDUAL OR ORGANIZATION NAMED BELOW:
(By checking one of the following, you will be charged a fee. For charts in paper format you will be charged $25.00 for the first 20 pages and .50 for each page thereafter . For records in electronic format you will be charged $25.00 for 500 pages or less and $50.00 for more than 500 pages.)

- ☐ Entire Record
- ☐ Psychiatric Evaluation **(No charge for evaluations sent to referring physicians and/or primary care physicians)**
- ☐ Other (Specify): _____
- ☐ Obtain medical records

_____ _____ _____
FULL NAME (Family Member / Doctor / Hospital / Attorney, etc.) Telephone Number Fax Number (optional)

_____
Address City State Zip

- **I understand that incomplete forms will be null and void; no exceptions.**
- I understand that specific information to be disclosed may include history of *Drug or Alcohol Abuse* or *Mental Health Treatment*, information concerning communicable diseases such as *Human Immunodeficiency Virus (HIV)*, and *Immune Deficiency Syndrome (AIDS)*, laboratory test results, treatment progress, and any other such related information. **This authorization will expire 1 year from the date of my signature.**
- I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.
- I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.
- I further authorize that a photocopy of this authorization is acceptable as an original.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.
- The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure. I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to: Privacy Officer: 7777 Forest Lane, Suite C-833 Dallas, TX 75230 **Phone:** 972-566-4591 **Fax:** 972-566-6679

_____ _____
Name of Patient or Personal Representative Date

_____ _____
Signature of Patient or Personal Representative Description of Personal Representative's Authority

_____ _____
Witness Date

Internal use ONLY:

Pages Copied_____ Date Request Completed_____ Completed By_____ Date Denial Sent_____
Charge $_____ Payment: ☐ Cash ☐ Check #_____ ☐ MC ☐ Visa ☐ Discover ☐ Am Ex