

**AUTHORIZATION TO RELEASE MEDICAL RECORDS**

**The Holiner Psychiatric Group**  
7777 Forest Lane, C-833, Dallas, TX 75230  
Office: 972-566-4591 Fax: 972-566-6679  
Joel Holiner, MD Robert Freele, MD Wajahat Ali, 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 if checked

**PLEASE RELEASE/OBTAIN COPIES OF MY MEDICAL RECORDS TO/FROM 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	_____ Email
_____ 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