

Authorization Form
For Release of Protected Health Information

By signing this form, I authorize you to use and disclose the protected health information described below.

Patient's Name: _____

Date of Birth: _____

The health information you may release subject to this authorization is as follows:

I hereby authorize and request the release of all medical records *from* the office of:

(Doctor or Medical Facility): _____

Address: _____

Phone: _____ **Fax:** _____

Release my protected health information *to the following doctor:*

Steven Peskind, M.D.
5957 Dallas Parkway, Suite 100
Plano, Texas 75093
Phone: 972-596-2552 Fax: 972-964-8745

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to Steven Peskind, M.D.

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 obtaining insurance coverage, as other law provides the insurer with the right to contest under the policy or policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my payment and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

Signature of Patient or Personal Representative

Date