Darren E. Meyer, M.D., Praveen Moolamalla, M.D.
and James Lawhorn, MS, LPC
1575 Heritage Drive, Suite 203
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Phone: 214-856-4483 Fax: 214-856-4487

AUTHORIZATION TO COMMUNICATE HEALTH INFORMATION

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

Patient Name: _____

Date of Birth: _____ SS#: _____

I authorize the office of **Darren E. Meyer, M.D., Praveen Moolamalla, M.D. and James Lawhorn, MS, LPC** to communicate regarding the above named individual's health information with:

Name: _____

Phone: _____ Address: _____

Fax: _____ _____

Please release the following:

_____ Progress Notes
_____ Laboratory Results
_____ Billing Records
_____ Complete Medical Record

Purpose of disclosure: (check one)

_____ Treatment
_____ Personal Request
_____ Legal reasons

I understand that the information my health record may include information relation 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.

I understand that I may revoke this consent/authorization at any time. This authorization will remain in effect until revoked by me in writing.

I understand that according to applicable state and/or federal laws (Texas Medical Practice Act or Health Insurance Portability and Accountability Act), a re-disclosure could be made of records received from another physician or other health care provider involved in my care or treatment.

Please note that there is a $25.00 fee for the copying and releasing of medical records. Please allow two weeks notice for releases.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Witness Signature

Prepared by (initials only) _____ Date _____