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# AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

**Per Texas Medical Board's guidelines, we charge $25 for pages 1 – 20, and 50¢ per page thereafter for records where applicable. Once we receive a completed written request and applicable records fees, we have 15 business days to respond under Texas law.**

Patient Name: ______________________________ DOB: ________________

| **Trey Aoueille, M.D.'s office is authorized to release my Personal Health Information (PHI) to:** | **Information may be released by:** (Check all that apply) |
|---|---|
| Name: ______________________ | ☐ Pick up at Office ☐ Email |
| Address: ______________________ | ☐ Mail ☐ Fax ☐ Phone |
| City/ST: ______________ Zip: ________ | **Expiration Date of Authorization:** This authorization is effective through _____/_____/_____ unless revoked or terminated earlier by the patient or the patient's personal representative. |
| Phone: ______________ Fax: ______________ | |
| Email: ______________________ | |

**INFORMATION TO BE DISCLOSED:** ☐ LAB RESULTS ONLY ☐ Genetic Test Results ☐ Treatment Plan

☐ Medication History Only ☐ Attending Psychiatrist Statement (includes psychiatric diagnosis and current medications)

☐ **Psychiatric Record** (May include all progress notes, symptom scales, prescription history, lab results, and patient correspondence) ☐ **All Dates** OR ☐**From Date:**________________ **To Date:**________________

☐ Other: ______________________________

**PURPOSE OF DISCLOSURE:** ☐ Continuity of Care ☐ Government Disability Benefits ☐ Insurance (Fee Applies)

☐ School Accommodations (Fee applies) ☐ Legal Purposes (Fee applies) ☐ Personal Use (Fee applies)

☐ Employer Disability Benefits (fee applies) ☐ Other (fee applies): ______________________

**RIGHT TO TERMINATE OR REVOKE AUTHORIZATION:** You may revoke or terminate this authorization by submitting a written revocation to our Office Manager (Privacy Official). **POTENTIAL FOR RE-DISCLOSURE:** Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once Dr. Aoueille's Office discloses it to another party. **RIGHTS OF THE INDIVIDUAL:** You may inspect or copy information used or disclosed under this authorization. You may refuse to sign this authorization. **EFFECT OF REFUSING AUTHORIZATION:** If you refuse to sign this authorization, Dr. Aoueille will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others (ie: treatment for enrollment or eligibility for benefits, etc.)

**Because we adhere to more stringent guidelines, we require this form completed in its entirety including the patient/guardian's handwritten initials and signature below before disclosing protected health information.**

**By initialing below, I give special permission to release information regarding: (select & initial all that apply)**

☐ **Psychiatric (Initial______)** ☐Genetic Info (Initial_____) ☐HIV/AIDS (Initial_____) ☐Substance Abuse (Initial______)

______________________________
Patient Signature Date

______________________________
Parent / Guardian Signature Date

______________________________
Staff Member / Witness Signature Date

______________________________
Staff Member / Witness Printed Name

**For Office Use Only:**
Copy given to patient on _____/_____/_____
Staff Members Initials: ______________