

North Plano Internal Medicine
Dr. Steven C. Strength
Board Certified - Internal Medicine
Disclosure Authorization Form/Medical Records Request

Patient: _____ Date of Birth: _____

I hereby give my authorization to disclose my PHI (protected health information) to the specific **individual(s) and/or facilities** listed below:

Description of information to be released:

I understand that the information in my health record may include information relating 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.
 Yes, I consent to the release of this information. **No**, I do not consent to the release of this formation.

Person(s) you are allowing to request and receive the information stated above:

Steve C. Strength, DO
6533 Preston Rd., Suite 100
Plano, Texas 75024
(972)473-8700 phone
(972)473-2303 fax

I understand this authorization provides that:

I have the right to access my protected health information (PHI) to be used or disclosed.

I may revoke this authorization at any time by contacting your Privacy Officer in writing at the address listed above.

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA privacy rules.

This practice will not condition treatment on my providing authorization for the requested use of disclosure.

I will receive a copy of this completed and signed authorization form.

Signature: _____ Date: _____

Relationship to patient (if signed by representative of minor or power of attorney):

Revised 03/26/08
