NARCISA A. DUSA, MD
INTERNAL MEDICINE
6300 W. Parker Rd • MOB 2 Suite 222 • Plano, TX 75093
888-5DR-DUSA • 972-981-7270 • 972-981-7271 Fax
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Authorization for Use and Disclosure of Protected Health Record Information

I give ____ (ph: ___-___-____/fax: ___-___-____)
my permission to release my protected health record information to:

NARCISA A. DUSA, MD • HEARST MEDICAL
6300 W. Parker RD. • MOB 2, Suite 222 • Plano, TX 75093
888-5DR-DUSA • 972-981-7270 • 972-981-7271 fax

Patient's Name: ______________________________ DOB: _ _ / _ _ / _ _ _ _
Date/s of Treatment: ______________________________ SSN: _ _ _ - _ _ - _ _ _ _

INFORMATION TO BE RELEASED

_ Discharge Summary	_ History & Physical	_ Operative Report	_ Pathology Report
_ Lab Reports	_ Consultation Reports	_ EKG/ECHO	_ ER Records
_ Shot Records	_ Progress Notes	_ X-Ray Reports	_ Psychiatric Records
_ Senior Health Records	_ Basics/Abstract	_ X-Ray Films/Imaging	_ Occupational Health
_ Complete Record	_ Itemized Bill		

_ Other: Please Specify ____

The information that is to be released from my medical records is for the following purpose:
_ Continued Medical Care _ Billing or Claims _ Attorney _ Social Security _ Patient Request
_ Other ____

Releasing Information about Drug Abuse, Alcohol Abuse, Psychiatric Care, and/or HIV/AIDS
I understand that even if my medical or billing records contain information that reference my drug abuse, alcohol abuse, psychiatric care, sexually transmitted disease history, Hepatitis B or C testing, and/or other sensitive information, I still agree to its release. **Please Check One: ___ Yes ______ No __________ Initials**

I understand that if my medical or billing record contains information that refers to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or or treatment, I still agree to its release. **Please Check One: ______ Yes ______ No _________ Initials**

Time Limit and Right to Revoke Authorization
Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to **Narcisa A Dusa, MD/Hearst Medical**.

Re-disclosure
I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Information Portability and Accountability Act (HIPAA - Act of 1996). **Naricsa A. Dusa, MD/Hearst Medical** and its employees are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative
I understand that **Narcisa A. Dusa MD/Hearst Medical** may not condition my treatment on whether or not I sign this authorization form. I authorize **Narcisa A. Dusa MD/Hearst Medical** to use and disclose the protected health information as specified above. I further understand that a reasonable copy fee may be charged for copies.

____ __ / __ / ____
Signature of Patient or Legal Representative **Date**

____ __ / __ / ____
Person with authority to sign if not the patient (documentation of authority required) **Date**

Identity of requestor verified by: ____Photo ID ____ Matching Signatures ______ Verified By (initials)