PLANO ORTHOPEDIC
& SPORTS MEDICINE CENTER

Authorization for Use and/or Disclosure of Protected Health Information (PHI)

Plano Orthopedic & Sports Medicine Center

5228 W. Plano Parkway · Plano, Texas 75093

Medical Fax Records 1-800-833-5935

Patient Name: _____ DOB: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

I hereby authorize Plano Orthopedic & Sports Medicine Center to disclose medical record information and/or PHI of the patient listed above to:

Name / Title: _____

Address: _____

Purpose: _____

For Treatment Date(s): _____

This consent is valid through this date: _____ If no date is provided, then the consent will expire 180 days from today's date.

Please select which portions of the medical record are to be sent to the person/organization above:

☐ History & Physical	☐ Lab	☐ Medication Record
☐ Consult Report	☐ Radiology Reports	☐ Outpatient Rehab
☐ Operative Report	☐ Path Report	☐ Progress Notes
☐ Discharge Summary	☐ Face Sheet	☐ Physician Orders
☐ Entire Record	☐ Other: _____	

_____ I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, and HIV testing and results.
initials

I understand that:

- This authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.
- Treatment and payment may not be conditioned on obtaining this authorization.
- The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.
- Fees/charges will comply with all laws and regulations applicable to release of information.
- A copy of this form will be made available to me upon my request.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Parent/Patient Representative | Relationship to Patient | Date

Address and Phone Number of Requestor (if different from patient information)