John M. Tieman, MD PA

HIPPA Patient Release for Personal Health Records

Name:_____ **Date of Birth**:_____ **Phone Number**:_____

To:(Provider/ Practice name)_____

Address:_____**Phone:**_____ **Fax:**_____

Please release the requested information TO:

Tieman Dermatology

1584 E. Common St. New Braunfels, TX 78130 P: (830) 609-4700 F: (830) 608-0470

Send Via: FAX HAND CARRY MAIL

Dates of Treatment: ALL OR From:_____ To:_____

Specific Reports that apply:

___ Entire Health Record

___Progress notes

___ Laboratory Reports

___Pathology Reports

___X-Ray Films or other Images

___ Other:_____

I give specific authorization to disclose the following information:

___HIV test results

___ Drug and Alcohol abuse treatment records

___ Documentation of AIDS diagnosis

___Psychiatric/Mental health treatment records

•I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the entity releasing the protected health information. I understand that the revocation will not apply to information that has already been released in response to this authorization. A revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

•I understand that signing this release is voluntary. Payment, enrollment or eligibility for benefits cannot be affected for refusal to sign this authorization, unless disclosure is directly related to these activities.

•I understand that the information disclosed may be subject to re---disclosure by the class of persons or entity receiving it, and in the event of re---disclosure is no longer protected by federal privacy regulations. If I am authorizing the release of HIV/AIDS---related, mental health---related, or alcohol or drug treatment information, the recipient is prohibited from re---disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law.

•This authorization will expire one (1) year from the signature date. Copy fees may be associated with this request.

•Information will not be released without a valid signature below.

_____

Signature of Patient (or Patient representative) Date

_____

Printed name of Patient (or Patient representative) Relationship to Patient