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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Please make sure to complete all sections, initial all applicable items above the signature line and sign below.
You may submit your release to Teri@TreyAoueilleMD.com or by fax at (512)329-5522.

Patient Name: _____ **DOB:** _____

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

INFORMATION TO BE DISCLOSED (check all that apply):

☐ **ENTIRE RECORD** ☐ Last 3 Progress Notes, Medication History and Labs ☐ Genetic Test Results (initials required)

☐ Records from: (insert date)_____ to: (insert date)_____ ☐ Medication History Only

PURPOSE OF DISCLOSURE:

☐ Continuity of Care with new Provider (no fee if sent directly to Providers Office)

☐ Personal Use (Fee applies)

RIGHT TO TERMINATE OR REVOKE AUTHORIZATION: You may revoke or terminate this authorization by submitting a written revocation to our 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 (i.e.: treatment for enrollment or eligibility for benefits, etc.)

Because we adhere to more stringent guidelines, we require this form completed in its entirety including your handwritten signature below before releasing your Protected Health Information (PHI).

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

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

Patient Signature **Date** _____ Parent / Guardian Signature _____ Date

_____ Staff Member / Witness Signature _____ Date _____ Staff Member / Witness Printed Name