

**ORTHOPEDIC & SPORTS MEDICINE INSTITUTE OF NEW BRAUNFELS**

DAVID TEMPLIN MD

MICHAEL VRANA MD

TRENT TWITERO MD

960 GRUENE RD., STE 101  
NEW BRAUNFELS, TX 78130  
PH- 830.625.0009 • FAX- 830.624.7505

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

**I hereby authorize the following Physician or Hospital to disclose the above named individual's health information:**

\_\_\_\_\_ Address \_\_\_\_\_

For the purpose of: \_\_\_\_\_

**Please release the following:**

- |                             |                    |                        |
|-----------------------------|--------------------|------------------------|
| _____ Admission Face Sheet  | _____ Consultation | _____ Physician Orders |
| _____ Discharge Summary     | _____ Op. Report   | _____ Nurse Notes      |
| _____ H & P                 | _____ Lab Record   | _____ Outpt Record     |
| _____ Progress Notes        | _____ Image Record | _____ ER Record        |
| _____ PT/RT/OT Record       | _____ Med Record   | _____ Office Record    |
| _____ Other (Specify) _____ |                    |                        |

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 information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a 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 physician or hospital releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: \_\_\_\_\_

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CRF 164.534. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact, Ellen M. Cochran, Privacy Officer.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship of Patient (if Legal Representative)

\_\_\_\_\_  
Witness

**COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:**

I understand that my medical records may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding for the information contained in these entries. I will not hold David B. Templin, M.D. liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient (If Legal Representative)

\_\_\_\_\_  
Witness

-----  
Date request completed \_\_\_\_\_ # paged copied \_\_\_\_\_ Reviewed only \_\_\_\_\_  
Charge \$ \_\_\_\_\_ Cash \_\_\_\_\_ Check # \_\_\_\_\_ Initials \_\_\_\_\_

This information has been released to you from records where confidentiality is protected by Federal Law. Federal Regulations (42CFR, Part 2) prohibits you from making any further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.