FAX THIS FORM TO YOUR PREVIOUS PHYSICIAN(S)
PRIOR TO YOUR APPOINTMENT WITH DR. ROACH

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL OR PROTECTED HEALTH INFORMATION

I authorize the following information regarding my treatment to be released from the medical record of:

Patient Name: ______________________________ DOB: _____________ SS#: ______________

Full Address: ____ Telephone #: ________________

THIS INFORMATION IS TO BE RELEASED:

TO: DOROTHY J. ROACH, M. D.
111 VISION PARK #110
THE WOODLANDS TX 77384-3003

FROM: YOUR TREATING PHYSICIAN
____
____

DATE OF APPOINTMENT: ______________________

INFORMATION TO BE RELEASED

- ○ COMPLETE RECORD
- ○ RECORDS OF CARE FROM THE FOLLOWING DATES: ___________ TO ___________
- ○ RECORDS CONCERNING THE FOLLOWING CONDITION (S): ______________________________________
- ○ OTHER, PLEASE SPECIFY: ____

FOR THE PURPOSE OF

- ☐ SECOND OPINION
- ☐ CONTINUITY OF CARE
- ☐ AT THE REQUEST OF THE INDIVIDUAL
- ☐ SHARING WITH OTHER HEALTHCARE PROVIDERS
- ☐ TRANSFERRING CARE TO A NEW PROVIDER
- ☐ OTHER____

HIV/AIDS: I CONSENT TO THE RELEASE OF ANY POSITIVE OR NEGATIVE TEST RESULT FOR AIDS OR HIV INFECTION, ANTIBODIES TO AIDS OR INFECTIONWITH ANY OTHER CAUSATIVE GENT OF AIDS WITH THE REST OF MY MEDICAL RECORDS:
INITIAL:___________ DATE:_______________

I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it, and would then no longer be protected by Federal or Texas Privacy law.

I understand that I may revoke this authorization in writing at any time by providing a written request for revocation stating my interest to revoke this authorization.

If information is being released to me, I understand that my medical record 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 of the information that has been written in the record. I will not hold NHCRM or Dorothy J. Roach, M. D. liable for any misinterpretation of the protected health information as a result of not consulting my physician for the correct interpretation.

This authorization shall be valid for one year from the date below unless revoked in writing by the patient prior to expiration date.

____________________________________ ____________________________________
Signature of Patient or Legal Representative Date