Medical Release of Information Form

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

Previous Name: _____

Home Phone: _____

Other Phone: _____

Address, City, State and Zip: _____

I request and authorize: _____

(Name and Address of Physician and/or Clinic/Practice you want to release your records) City & State: Zip Code: Phone: Fax:

To release the medical record of the above named patient to:

RESTORE Center for Integrative Medicine

Ayesha Aman MD, MPH

6517 W. Plano Parkway Suite A

Plano, TX 75093

Reason for release (required field): _____

Health Care information relating to the following treatment condition or dates of treatment: _____

This information may contain x-ray reports, laboratory reports, EKG reports, other diagnostic reports, consults, etc.

This request and authorization applies to: (initial appropriate line)

_____All Health Care information including information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use. (Please circle all that apply)

_____All Health Care Information excluding information relating to HIV/Aids testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use. (Please circle all that apply)

_____Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. Treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes.

I understand I have the right to revoke this authorization by providing a written request to the above name physician or organization. I understand that the revocation will not apply to information that has already been released in good faith. I understand that the condition for release is not based on payment for treatment and care, enrollment or eligibility on whether I sign the authorization.

_____ _____

Signature of patient or authorized representative Date

Relationship or status if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

Unless otherwise revoked this Authorization will expire six months from the date signed or the following designated
event:_____
_____

I understand that authorizing the disclosure of this health information is voluntary.

Patient Name:
Social Security #:
Home Phone:
Address, City, State, Zip I request and authorize:

Address: RESTORE Center for Internal Medicine

Ayesha Aman MD, MPH

6517 W. Plano Parkway, Suite A, Plano, Texas 75093