



**Segal Family Medicine Center, P.A.**  
 6537 Preston Road  
 Plano, TX 75024  
 Phone: 972 379-2096 · fax 972 379-2054

**AUTHORIZATION OF RELEASE OF INFORMATION TO SEGAL FAMILY MEDICINE CENTER**

I hereby authorize \_\_\_\_\_

Entity/Person from whom records are requested; include full name

Complete address

City, State, Zip, Telephone, Fax

I hereby authorize the above entity/ person to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus (“HIV”) and Acquired Immune Deficiency Syndrome (“AIDS”), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company of non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

Printed Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_

Patient Address: \_\_\_\_\_

Dates of Service (if known): \_\_\_\_\_ or  ALL

**Description of information to be released:**

- |   |   |   |                                       |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Emergency Room     | <input type="checkbox"/> Radiology Reports    | <input type="checkbox"/> Admission/Registration | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Records                | _____                                 |
| <input type="checkbox"/> Nurses’s Notes     | <input type="checkbox"/> Physician’s Orders   | <input type="checkbox"/> Laboratory Reports     | _____                                 |
| <input type="checkbox"/> Progress Notes     | <input type="checkbox"/> Operative Records    | <input type="checkbox"/> Billing Records        | _____                                 |
| <input type="checkbox"/> Discharge Summary  | <input type="checkbox"/> Radiology Reports    |   |                                       |

**Description of the purpose of the use and /or disclosure:**

**The health information described herein shall be released to:**

**Segal Family Medicine Center**  
**6537 Preston Road**  
**Plano TX 75024**

**Phone Number: 972-379-2096**  
**Fax Number: 972-379-2054**

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until \_\_\_\_\_ (Expiration date/event).

I further understand that I may revoke this authorization at any time by notifying this practice in writing at the address listed above. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

\_\_\_\_\_  
**Signature of Patient or Patient’s Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name of Patient Representative**

Irwin M. Segal, M.D, C.M. · Aaron P. Segal, M.D. · Stephanie L. Segal, M.D.  
 Anna Segal *Practice Administrator*, Gypsy Cassidy *Office Manager*