STEPHEN I. ESSES, M.D./SOUTHWEST ORTHOPEDIC GROUP

RECORDS RELEASE AUTHORIZATION FORM

Authorization for: ☐ **Disclosure** ☐ **Inspection** ☐ **Amendment** ***of Protected Health Information.***

Patient Name: _____ **Date of Birth:** _____

Social Security: _____ **Phone:** _____

Patient Address: _____

……..

I hereby authorize _____
(Facility Name)

to release information from the medical records of _____
(Patient's Name)

to: _____STEPHEN I. ESSES, M.D. – 6560 FANNIN SUITE 1100 HOUSTON, TX 77030_____
(Name / Address of person / organization to which disclosure is to be made)

FAX Number _____713/ 333- 4111_____ Phone Number _713/ 333-4110_____

For the following Treatment Dates: _____
(Specify Dates – MUST BE Completed)

For the following purpose: ☐ Medical Care ☐ Legal ☐ Insurance ☐ Other: _____

Please select what Portions of the Record.

☐ Abstract/Pertinent Information	☐ MD Orders
☐ Lab	☐ MD Progress Notes
☐ Emergency Room	☐ Face Sheet
☐ Imaging / Radiology	☐ Operative / Procedure Report
☐ Nursing Notes	☐ Entire Record EXCLUDING – HIV Testing & Chemical Depend.
☐ H & P	☐ Entire Record INCLUDING – HIV Testing & Chemical Depend
☐ Cardiac Studies	☐ Entire Record INCLUDING – HIV Testing ONLY
☐ Itemized Bill	☐ Entire Record INCLUDING – Chemical Dependency Only
☐ Other: _____	

This authorization is valid until the 180th day after the date it is signed unless it provides otherwise, not to exceed 24 months or unless it is revoked and covers only treatment(s) for the dates specified above.

I, the undersigned, have read the above and authorize to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taking in reliance upon it. I understand that when this information is used to disclosed pursuant to this authorization, if may be subject to re-disclosure by the recipient and many no longer be protected. I hereby release and hold harmless the above named facility and its parent company from all liability and damages resulting form the lawful release of my Protected Health Information.

_____ _____ _____
Signature of Patient/Parent/Conservator/Guardian | Authority/Relationship to Patient | Date