Medical Records Release Authorization

Pink Link Medical
Kala DeHaan RN, WHCNP
4708 Alliance Blvd
Suite 645
Plano, TX 75093
T 469.458.0296 F 214.291.2503
kala@pinklinkmedical.com

Name_____ **Birthdate** _____/_____/_____

Date _____/_____/_____ **Phone (** **)** _____ -_____

Address_____

City _____**State** _____**Zip** _____

I hereby authorize

Kala DeHaan RN, WHCNP
4708 Alliance Blvd, Suite 645, Plano, TX 75093

To release my medical information

To:_____

_____

_____

phone (____)_____-_____ fax(____)_____-_____

OR

I hereby authorize
the release of my medical information

To: Kala DeHaan RN, WHCNP
4708 Alliance Blvd, Suite 650, Plano, TX 75093
T 469.458.0296 F 214.291.2503
kala@pinklinkmedical.com

From: _____

_____

_____

phone (_____) _____-_____ fax (_____) _____-_____

Purpose for Need of Disclosure, at the request of the individual. _____ **(please check)**

Are you terminating your relationship with this practice? (please circle one) Yes No

Information to be released:

_____Complete Medical Records (including all of the below, or check specific record need)

_____Medical History
_____X-ray and Radiology Reports
_____Laboratory Reports
_____Mental Health
_____Sexually Transmitted Disease Reports
_____Alcoholism
_____Developmental Disabilities
_____Surgical Reports
_____Hospital Records and Reports
_____Prescriptions
_____Consultations
_____Drug Abuse and Tobacco Use
_____Allergy Records
_____HIV Test Results
_____Other, Specifically _____

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be re-disclosed without obtaining my authorization.

I understand that I have the right to:

- **Receive Copy of This Authorization.**
- **Refuse to Sign This Authorization,** and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.
- **Revoke This Authorization,** except to the extent that the person(s) and or organization(s) listed above have already made in reference to this authorization.

This authorization will have an expiration date of: _____ or one year if not otherwise specified.

Pink Link Medical will charge $25.00 for creating a digital copy of your records. We must receive payment before records can be copied, faxed, or mailed out. We accept cash, credit cards, and personal checks.

_____ **Signature of Patient (or Legal Representative)**