# AUTHORIZATION FOR RELEASE OF INFORMATION

| | |
|---|---|
| **Patient's Full Name** | **Patient's Social Security Number** |
| **Address** | **Patient's Date of Birth** |
| **City, State, Zip Code** | **Patient's Telephone Number** |

I hereby authorize disclosure of 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 this authorization is voluntary, and I may refuse to sign this authorization. I further understand that my health care and payment of my health care will not be affected if I do not sign this form.

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

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

   _____

2. The following person (or class of persons) may receive disclosure of protected health information about me:

   **Enid S. Romanelli, M.D., Yolanda Clay-Po, M.D., Cristina Valdez, M.D., Alexis Fitzgerald, PA-C**

   **Diana Chavez, FNP-C, Stephanie Fierros, PA**

   **1141 Kinwest Parkway, Suite 100 Irving TX, 75063**
   **Address**

   | **(214) 239-2222** | **(214) 239-2223** | **records@yourclinic.com** |
   |---|---|---|
   | **Phone Number** | **Fax Number** | **Email** |

3. The specific information that should be disclosed is:

   _____

   _____

4. I understand that this authorization will expire by law 180 days from the date of this authorization, unless otherwise indicated.

   - I desire this authorization to be in effect until (Expiration event/date): _____/_____/_____

I understand that I may revoke this authorization at any time by notifying E.S. Romanelli, M.D., P.A. in writing at 1141 Kinwest Pkwy, Suite 100, Irving TX 75063. I also understand that the written revocation must be signed and dated with a date that is later than the date of authorization. The revocation will not affect any action taken before receipt of written revocation.

| | | |
|---|---|---|
| **Signature of Patient or Patient Representative** (If minor, please complete the information below) | **Date** | **Date of Birth or Social Security Number** |
| **Printed Name of Patient Representative** | **Relationship to Patient** | or **Legal Authority (attach supporting documentation)** |