SCOTT R. ELKIN, DO, PA
3705 MEDICAL PKWY #450
AUSTIN, TEXAS 78705
OFFICE: 512.306.0061
FAX: 512.306.0069

For Office Use Only:
□ Authorization added to patients medical record on: _____.
□ Authorization verified by _____ on _____.
□ Patient has been provided with a copy of the signed authorization: □ Yes □ No

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Scott R. Elkin, D.O. to □ release / □ obtain (check one) medical information concerning:

Patient Name _____ DOB _____ SSN _____

Address _____ Dates of Service _____

City _____ ST _____ Zip _____ Phone _____

This information is to be □ released to / □ obtained from:

Name _____

Address _____

City / ST _____ Zip _____

Phone _____ Fax _____

Records may be released via:
(Check all that apply)
□ Mail: Scott R. Elkin, DO
3705 Medical Parkway #450
Austin, TX 78705

□ Phone: (512) 306-0061

□ Fax: (512) 306-0069

Please release the following information, indicated by a "√":

□ History & Physical	□ Consultation	□ Nutrition Consultation	□ Family Planning Record
□ Lab Results / X-Rays	□ Operative Report(s)	□ Social Work Notes	□ Tuberculosis Elimination Records
□ Maternity Record	□ Psychotherapy Notes	□ WIC	□ Other:

I also give special permission to release any information regarding items listed below:
□ HIV Medical Information (Initial_____) □ Psychiatric (Initial_____) □ Substance Abuse Records (Initial_____)

This information is necessary for the following purposes:

□ Continuity of care	□ Patient/Guardian requests disclosure	□ Disability Benefits
□ Attorney (fee applies)	□ Other:	(fee applies)

<u>The patient or the patient's representative must read the following statement</u>:

I, the undersigned, understand that I may revoke this consent at any time in writing, except to the extent that action has been taken in reliance on it and that in any event this consent shall expire in one (1) year from when it is signed unless otherwise specified (Otherwise specified date:). I understand that the provision of my health care and the payment for my health care will not be affected if I do not sign this form. Upon expiration, Dr. Elkin can no longer use or disclose my information for the above purposes without a new authorization. All revocations will be sent to the attention of Dr. Elkin's Privacy Representative and become effective once received.

I understand that the above information may include records/reports from other health care providers involved in my care or treatment. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information.

I understand any of the above equested information may include results of sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), and Human Immunodeficiency Virus (HIV) tests if any were performed. Further, I understand any of the above requested information may include results of alcohol/drug (substance) abuse and/or diagnosis and treatment of psychological disorders.

I understand that I may see and obtain a copy of the information described on this form if I ask for it, and that I get a copy of this form after I sign it.

Patient / Representative Signature _____ Date _____ Relationship to Patient: □ Self □ Parent □ Guardian

Reason Patient is not Signing _____

Witness _____

TO THE PARTY RECEIVING THIS INFORMATION: This information is being disclosed to you from records where confidentiality may be protected by federal and/or state laws. If so, regulation 42 CFR, Part 2, prohibit further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation.