Paul T. Moore M.D.

Authorization to Obtain or Release Patient Health Information Patient

Name:_____

Birth Date:_____Phone Number:_____

I authorize:
Paul T. Moore M.D.
8722 Greenville Ave, Suite 102
Dallas, Texas 752243
Phone: 214-466-7222 Fax: 214-466-7220

To Obtain / Release my records to / from the following individual or organization listed below:

Physician or Clinic Name:_____

Address:_____

Phone:_____Fax:_____

The type of information to be obtained / Released is as follows:

_____Entire Health Records _____ Imaging _____Lab Reports

_____Office Notes _____Billing Records _____Sleep Study Reports

Purpose:
_____Continue Care by another Provider _____Other
_____I understand that this authorization will expire 180 days from the date of this authorization.

This authorization is given freely with the understanding that:

1. Any and all medical records, whether written, oral or electronic format, are confidential and cannot be disclosed without prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this is valid as the original.
3. I may revoke this authorization at anytime, except where information is already been released. To revoke my authorization, I must submit a Revocation of Authorization of Medical Information Form to the office.
4. Dr. Moore and his employees are hereby released from any legal responsibility or liability for disclosure f the above information to the extent indicated and authorized herein.
5. Information used or disclosed pursuant to the authorization may be subject to disclosure by the recipient and may no longer be protected by this rule. 6. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining this authorization.

_____

Patient/Legal Guardian Signature Date