AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, __________________________________ hereby authorize _________________________________ to

disclose the protected health information described below for the following purpose(s):

Surgery Clearance

The health information to be used and/or disclosed is specifically described as follows: ________________

Person or class of persons to whom the information will be disclosed or who will use the information is:

William P. Adams, Jr., M.D.
2801 Lemmon Ave West, Suite 300
Dallas, Texas 75204
Ph: 214-965-9885 Fax: 214-969-0933

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to this practice. I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

____
Signature of Patient or Personal Representative

____
Date

____
Patient's Date of Birth