Authorization to Release Protected Health Information

Patient Name:_____ Date of Birth:_____

Release of Information From: (Specify facility/individual & phone/fax if known)

☐ John G. Tierney, M.D.
508 E. San Antonio Ave
Boerne, TX 78006
Phone: (210) 615-8458
Fax: (210) 615-8459

☐ _____
_____
_____
_____

Release Information To:

☐ John G. Tierney, M.D.
508 E. San Antonio Ave
Boerne, TX 78006
Phone: (210) 615-8458
Fax: (210) 615-8459

☐ _____
_____
_____
_____

Purpose of Release:

___ Treatment/Continued Care
___ Application for Insurance
___ Other: _____
___ Personal
___ Disability Determination
___ Legal Purposes
___ Payment of Insurance Claim

Information to be Released:

___ Clinic/Progress Notes(Last 3mos)
___ Current Medication/Allergy List
___ Financial Reports/Statements
___ Other: _____
___ EKG/Current Lab Reports
___ Radiology Images/Reports
___ CT/MRI Reports
___ Hospital Notes
___ Hospital Discharge Summary
___ Psych/Neuropsych Testing

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that my medical records may contain reports, test results, and notes that only a physician can interpret. I **understand and have been advised** that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. **I will not hold John G. Tierney, M.D., M.A. liable** for any misinterpretation of the information in my medical record as a result of **not** consulting my physician for the correct interpretation.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing the information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company in cases that the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization expires one year from the date signed, or:** _____.
Month/Day/Year

I understand that authorizing the disclosure of this health information is voluntary. **I can refuse to sign this authorization.** I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164-524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness

_____ _____
Address Phone Number