TEXAS
INFECTIOUS DISEASE
INSTITUTE

PATIENT DISCLOSURE FORM

Authorization to Disclose Health Information

Name of Patient: _____

Date of Birth: _____ Social Security #: _____

I authorize the following individual or organization to disclose the above named individual's health information

_____ (MD) Address: _____

This information may be disclosed to and used by the following individual or organization:

Serge Lartchenko, MD
2821 East President Bush Hwy
Suite 500
Richardson, TX 75082
855.77.TXIDI (89434)
FAX 469.206.6953

The Type and Amount of information to be used or disclosed is as follows: (Please check)

All patient medical information (physician H&P, progress notes, other medical, imaging & laboratory reports)
Patient's driver license and Insurance Card
Other: _____

I understand that the information in the patient's health record may include information relating to sexually transmitted disease, Acquired Immune Deficiency 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 I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to my insurance company, when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year.

I understand that the information may not be protected by federal privacy regulations.

I understand that I will be given a copy of this authorization form after signing, only if I request one.

_____

Signature of Patient / Responsible Party or Legal Representative Date

_____

If signed by Legal Representative, Relationship to Patient Date

_____

Physician Signature Date