



William F. Tucker, Jr., MD, PA
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ORTHOPAEDIC SURGERY & SPORTS MEDICINE of DALLAS

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

(Please Print or Type)

Patient Name: _____ Social Security Number: _____

Address: _____ Date of Birth: _____

City, State, Zip: _____ Phone Number: _____

I hereby authorize William F. Tucker, Jr., MD, PA, to release information from my medical record by

Mail Fax Email to:

Name Texas Joint Institute

Address 12228 North Central Expressway, Pavillion 3, Suite 410

City, State, Zip Dallas, TX, 75243

Tel Number 469-291-1511 Fax Number 972-566-5236 Email Address _____

Purpose of this Release: _____

My authorization is confined to the following specific information initialed below:

- | | |
|-------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| _____ Statements for charges or payments | _____ Mental health and/or alcohol and drug abuse treatment |
| _____ Progress notes | _____ AIDS (Acquired Immunodeficiency Syndrome) or HIV
(Human Immunodeficiency Virus) information |
| _____ Discharge summary | _____ Hepatitis information |
| _____ Consultation reports | _____ Records or reports for visits (all visits) |
| _____ Records or reports of visits for specific date(s) of: _____ | |
| _____ Photographs, digital, or other images | |
| _____ History and physical examination | |
| <input checked="" type="checkbox"/> All of the above | |
| _____ Other (Must be specific) _____ | |

This authorization is given freely with the understanding that:

- Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
- A photocopy or fax of this authorization is as valid as this original.
- I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available upon request.
- William F. Tucker, Jr., MD, PA, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure for the above information to the extent indicated and authorization herein.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon this authorization.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

PATIENT OR PERSONAL REPRESENTATIVE'S
NAME PRINTED

DATE, EVENT, OR CONDITION OF EXPIRATION
(IF OTHER THAN ONE YEAR FROM DATE SHOWN ABOVE)

PATIENT OR PERSONAL REPRESENTATIVE'S
SIGNATURE

DATE

WITNESS

DATE