TO: _____

Patient Identification

Printed Name: _____ **Date of Birth:** _____

Address: _____

_____

Social Security #: _____ **Telephone:** _____

Information to Be Released – Covering the Periods of Health Care

From (date) _____ to (date) _____

From (date) _____ to (date) _____

Please Check Type of Information to be Released:

_____ Entire Medical Record	_____ Pathology Report	_____ Discharge Summary
_____ History and Physical Exam	_____ Consultation Reports	_____ Progress Notes
_____ Laboratory Test Results/Reports	_____ X-Ray Reports	_____ X-Ray Films/Images
_____ Operative Report	_____ Emergency Room Record	_____ Itemized Bill
_____ HIV/AIDS Testing and Treatment	_____ Drug and/or Alcohol Abuse	_____ Psychiatric Records

_____Other, (specify) _____

Purpose of Request

_____ Treatment or Consultation _____ At Request of Patient _____ Billing/Claims Payment

_____Other, (specify) _____

Person Authorized to Receive Information

Name: Ross Reporting Services, Inc. Address: 11706 Playa Court, Houston, Texas 77034

Time Limit & Right to Revoke Authorization

This authorization is valid until the 12th month after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked, and covers only treatment(s) for the dates specified above. This consent is subject to written revocation by the undersigned at any time except to the extent that action has been taken and if not earlier revoked. To revoke this authorization contact the above mentioned facility for assistance.

Re-Disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Electronic Medium/Digital

I understand that all documents may be stored, transferred and/or provided by digital or electronic medium if possible.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that the above mentioned facility may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I authorize the above mentioned facility to use and disclose the protected health information specified above.

Signature: _____ **Date:** _____

Authority to Sign if not patient: _____

Subscribed and sworn to before me on this the _____ day of _____, _____.

_____

Notary Public in and for the State of Texas

*** A PHOTOSTATIC COPY OF THIS RELEASE SHALL BE CONSIDERED AS VALID AS THE ORIGINAL***