Jennifer Aldrich, MD
Phone: 214-382-5810
Fax: 855-479-1759
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Authorization for Release of Protected Health Information

Patient Name: _____ DOB: _____

Telephone:_____

Address: _____

Receive Records From:

Name

_____

Address

_____

City, State, Zip

_____

Phone #

_____

Fax #

_____

Release Records To:

Jennifer Aldrich, MD

8335 Walnut Hill Ln

Suite 100

Dallas, TX 75231

Ph: 214-382-5810

Fax: 855-479-1759

Please send a copy of my records as indicated for the date/dates of treatment: _____

( ) Entire Record	( ) X-Ray/Imaging	( ) Operative Reports
( ) Laboratory Test Results	( ) Consultation Reports	( ) History & Physical
( ) Discharge Summary	( ) ER Records	( ) Pathology Reports
( ) Other: _____		( ) Transition of Care

I understand that I may revoke this authorization in writing at any time prior to the release of information specified above. I hold harmless Jennifer Aldrich M.D. and/or its representatives from any and all liability resulting in the release/obtaining of the above information. This authorization expires in 90 days from the date signed. I also understand, if the person receiving this information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the receipt may be prohibited from disclosing my health information under applicable state or federal laws and regulation. I further understand that the person/s I am authorizing to use or disclose my information may receive compensation for doing so.

Signature: _____ Date: _____