Texas Psychiatry Associates, PA

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TO: Innovated Minds-Texas Psychiatry Associates, PA Talat Tayyaba, MD/Syed Quadri, MD
Name of Healthcare Provider/Physician/Facility/Medicare Contractor
3417 Spectrum Boulevard, Suite 200 Richardson, TX 75082
Street Address City, State & Zip Code

RE: Patient Name: _____
Date of Birth: _____ Social Security Number: _____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

____ All medical records, meaning every page in my record, including but not limited to: office notes, facesheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.
____ All physical, occupational and rehab requests, consultations and progress notes.
____ All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.
____ All employment, personnel or wage records.
____ All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.
____ All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
____ All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period _____ to _____.

This protected health information is disclosed for the following purposes:

__-_____

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived. You are authorized to release the above records to the following representatives of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of such records:

_____
Facility/Name of Doctor for which the records are to be sent to
_____
Street Address City, State & Zip

I understand the following: See CFR §164.508(c)(2)(i-iii)
a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein.
This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____ _____
Signature of Patient or Legally Authorized Representative Date
(See 45CFR § 164.508(c)(1)(vi)) (See 45CFR §164.508(c)(1)(iv))

_____ _____
Witness Signature Date