***PATIENT #*_____**

Steven M Pounders, MD, PLLC
3500 Oak Lawn, Suite 600
Dallas, TX 75219-4373
214-520-8833 Fax 214-520-2956

REQUEST FOR RELEASE OF MEDICAL RECORDS

PATIENT RECORDS AND INFORMATION PERTAINING TO:

Patient Name:_____

Address:_____

City:_____State:_____Zip:_____

Social Security Number: __ __ __ - __ __ - __ __ __ __ Date of Birth: __ __ / __ __ / __ __ __ __

Phone Number: __ __ __ - __ __ __ - __ __ __ __

I AUTHORIZE:
Name of Disclosing Doctor/Party:_____

Address:_____

City:_____State:_____Zip:_____

Phone Number: __ __ __ - __ __ __ - __ __ __ __ Fax Number: __ __ __ - __ __ __ - __ __ __ __

to dispose to:

Steven M Pounders, MD, PLLC
3500 Oak Lawn, Suite 600
Dallas, TX 75219-4373
214-520-8833 FAX 214-520-2956

I, _____requesting and authorizing that any and all medical information pertaining to my diagnosis and treatment be released to Steven M. Pounders, MD, PLLC to include Laboratory, EKG, Stress Tests, Echoes, Nuclear Studies, Hospital Admission and Discharge Summaries, Medical Treatment and Treatment Progress, or information (including information regulated by 42 USC Section 290dd3 (alcohol) and 290ee3 (drug abuse) and mental information regulated by TEX,CIV,STAT.ANN, Article 5561H, 5547-87, Texas Rule of Evidence, Rule 510, and Article 4419(b)-1, VTCS (HIV). The releases of my records are so that I may continue to receive medical care. I understand that my medical records (including alcohol, drug abuse, and mental status information and HIV test results) are protected by Federal Regulation and/or State Law. I also understand that I may revoke this consent at any time, except for action which was taken based on it, by sending written notification to the practice's Privacy Contact at 3500 Oak Lawn, Suite 600, Dallas TX 75219. The office of Steven Pounders, MD, PLLC will condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use of disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. This consent will expire in 90 days.

_____ _____
Signature of Patient, Parent, Guardian, or Legal Representative Date

This information is confidential pursuant to Federal and State Law and is protected from further disclosure without the specific written consent of the above individual(s).