

**Dr. Diane Nguyen, D.O., PLLC**  
**1010 Ranch Rd 620 S., Suite 108**  
**Lakeway, TX, 78734**  
**Ph: 512.502.4556 Fax: 512.263.9975**

**Authorization for Release of Protected Health Information**

Patient's name: _____ Date of Birth: _____
Address: _____
City/State/Zip Code: _____
SS#: _____ Patient's phone #: (    ) _____

<b>I authorize Dr. Diane Nguyen to:</b> <input type="checkbox"/> release and/or <input type="checkbox"/> obtain ___ <b>Information pertaining to my medical/surgical history, including HIV and STD results</b> ___ <b>Drug and alcohol use/dependency history, evaluations, and treatments</b> ___ <b>Psychiatric/mental health records including psychological evaluations and therapy notes</b> ___ <b>Conversations as needed regarding status of care</b> ___ <b>Other:</b> _____
<b>From/To:</b>
_____ Name
_____ Address
_____ City, State, Zip Code
_____ Phone #/Fax # (include area code)

**PURPOSE FOR THIS REQUEST:** (Check one.)  Healthcare  Personal  Other  Transfer of Care  
**DATE RANGE FOR RECORDS REQUESTED:** \_\_\_\_\_ to \_\_\_\_\_

**AUTHORIZATION VALID FOR:** (Check one.)  
 One year from the date of this authorization  
 From today until \_\_\_\_\_. (Insert date.) This authorization applies to the records of the treatment received on or prior to the date of this authorization.

***I understand that:***

- My right to healthcare treatment is not conditioned on this authorization.
- The records created by Dr. Nguyen are Mental Health record and includes substance use history/abuse history and other very personal information.
- Dr. Nguyen maintains the right to refuse to release some information if it is not in the best interest of the patient.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- There may be a reasonable charge for the requested records that must be received PRIOR to release.
- It may take up to 15 business days after receipt of this request AND PAYMENT for your records is released.
- Dr. Nguyen is not responsible for what happens to the records once it has been released and I understand that there are risks to releasing my medical information.

Signature of Patient or Representative \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient (if requester is not the patient) \_\_\_\_\_