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 #: ( ) _____

I authorize Dr. Diane Nguyen to: □ **release and/or** □ **obtain**
___ **Information pertaining to my medical/surgical history, including HIV and STD results**
___ **Drug and alcohol use/dependency history, evaluations, and treatments**
___ **Psychiatric/mental health records including psychological evaluations and therapy notes**
___ **Conversations as needed regarding status of care**
___**Other:** _____
From/To:

_____
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)* _____