Shannon L. DeShazo, M.D.
5236 W. Univeristy Dr. #3200
McKinney, TX 75071
972-548-1717 (phone)
972-548-9190 (fax)

Authorization of Release of Medical Information

(Please print neatly & legibly)
Patient's Name: _____ **DOB:** _____
Phone #: _____ **SS #:** _____
Address: _____
_____

I authorize records: (please select one)
[ ] To be released ***TO*** Shannon L. DeShazo, M.D. from_____
Address: _____
Phone: _____ Fax: _____

[ ] To be released ***FROM*** Shannon L. DeShazo, M.D. to _____
Address: _____
Phone: _____Fax: _____

I request release of the ***complete health record(s)*** for *all* ***dates of service*** unless specified here: _____
_____
_____

The purpose of this disclosure is for ***treatment/payment/healthcare operations*** unless specified here: _____
_____

This authorization gives Shannon L. DeShazo, M.D. permission to request your medical records from any health care provider that you have received treatment from as specified above for the duration that you have a direct treatment relation with Shannon L. DeShazo, M.D. Shannon L. DeShazo, M.D. is authorized to furnish information even though the confidentiality of the information may be protected by Federal or State laws & regulations. **This includes any and all alcohol &/or drug treatment records or psychiatric records and any information related to HIV or sexually transmitted disease testing or results that are in the record, unless otherwise specified above.** Shannon L. DeShazo M.D. is released and discharged from any liability, and the undersigned will hold Shannon L. DeShazo, M.D. harmless for complying with this information. I understand that I am not required to sign this authorization. I understand that I may revoke this authorization at any time by presenting my written revocation for Shannon L. DeShazo, M.D., 4510 Medical Center Drive, Suite 210, McKinney, TX 75069. I understand that the revocation will not apply to information that has already been used or released under this authorization. I understand that physician's office has the right under Texas state law to require payment up front for reasonable costs of copying and mailing before furnishing the medical records.

_____ _____
Signature of Patient or Legal Representative Printed Name of Patient or Legal Representative

_____ _____
Relationship to patient or Legal Representative Date

_____ _____
Witness Date

NOTICE TO PERSON OR AGENCY RECEIVING THIS INFORMATION: *This information has been disclosed to you from records whose confidentiality is protected. Laws & regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient.*