accura health
primary & post-acute care management

AUTHORIZATION OF DISCLOSURE OF INFORMATION

Patient Name: _____
DOB: _____
Address: _____ **City**: _____ **State**: _____
Zip: _____

I hereby authorize the disclosure of my protected health information as described below to:
ACCURA HEALTH LLC
Address: **3635 North Beltline Road, Ste 110, Sunnyvale, TX 75182**
Phone: **972-559-4150**

THE INFORMATION TO BE DISCLOSED IS LIMITED TO (CHECK ITEMS TO BE DISCLOSED)

☐ **Progress Notes**
☐ **Labs**
☐ **X-Ray/EKG**
☐ **Office Visits**
☐ **Hospital Visits**
☐ **Treatment Notes**
☐**Other (please specify): _____**

SPECIAL AUTHORIZATION FOR RELEASE Of RECORDS FOR MENTAL REHABILITATION, ALCOHOL OR DRUG ABUSE AND/OR DEPENDENCY, HIV ANTIBODY TESTS AND/OR AIDS DIAGNOSIS AND TREATMENT.
(PLEASE INITIAL IF APPLY)

____Include information related to diagnosis and/or treatment for alcoholism and/or drug abuse and/or dependency.
_____Include information related to HIV test results and/or AIDS diagnosis and treatment. • A listing of the statutory related to HIV test results without consent is available. Purpose or Need of Disclosure
_____At the request of the individual I understand that I have the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be re disclosed without obtaining my authorization. I understand that I have the right to:

- Receive a copy of this authorization
- Refuse to sign this authorization, and that treatment, payment, enrollment, in a health plan eligibility for health care benefits may not be contingent on my signing this authorization.
- Revoke this authorization except on the extent that the person(s) and organization(s) listed above has already made in reference to this authorization

Signature: _____ **Date**: _____