# William L. Mulchin, M.D.

DIPLOMATE OF THE AMERICAN BOARD OF UROLOGY
FELLOW OF AMERICAN COLLEGE OF SURGEONS
ADULT & PEDIATRIC UROLOGY

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## Record Release

Patient Legal Name: _____

Date of Birth / Social Security Number: _____

Address: _____

I hereby authorize _____
Facility or Covered Entity
To disclose medical record information and/or protected information of the patient listed about to William L. Mulchin, MD for treatment date(s):

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Type of Access Requested:

_____ Copies of the records

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_____ I acknowledge, and hereby consent to such, that the released information may contain alcohol abuse, drug abuse, psychiatric, HIV testing, HIV results or AIDS information.

Expiration: This authorization shall expire on the 180th day after it is signed, unless as provided otherwise upon the expiration date or event given here:

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I understand that I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to _____ receiving the revocation. Further details may be found in the Notice of Privacy Practices.

If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.

Copy fees/charges will comply with the Texas Health and Safety Code, Chapter 241 and all other laws and regulations applicable to release of information.

I understand that treatment and payment are not a condition of signing this authorization. I may receive a copy of this form after I have signed it.

I have read the above and authorize the disclosure of the protected health information as stated.

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**Signature of Patient/Parent/Patient representative** **Relationship to Patient** **Date**