



Kidney/Pancreas Transplant Program
1411 N Beckley Ave., Pavilion III, Suite 261
Dallas, Texas 75203
214-947-1800/ Fax 214-947-1828

Authorization to Disclose Health Information

Name of Patient: \_\_\_\_\_ ("Patient")
Please print

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I authorize the following individual or organization to disclose the above named individual's health information:

\_\_\_\_\_ Address: \_\_\_\_\_

This information may be disclosed TO and used by the following individual or organization:

Methodist Dallas Kidney/Pancreas Transplant Program
1411 N Beckley Ave., Pavilion III, Suite 261
Dallas, Texas 75203

The type and amount of information to be used or disclosed is as follows: (Please check):

- All pertinent medical information (physician H&P, progress notes, other medical, imaging & laboratory reports) relative to kidney/pancreas disease or
Operative Report or Procedure Report, specifically
Other

I understand that the information in the Patient's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information is being disclosed for the following purpose(s): \_\_\_\_\_

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire in one year.

I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

I understand that I will be given a copy of this authorization form after signing, only if I request one.

Signature of patient/Responsible Party or Legal Representative Date: \_\_\_\_\_

If signed by Legal Representative, Relationship to Patient Date: \_\_\_\_\_

Signature of Witness Date: \_\_\_\_\_