

*A Place  
Of  
Caring*

Hope Speaks, PLLC  
medicalrecords@hopespeaks.com  
1200 East Collins Blvd. Suite #300  
Richardson, Texas 75081  
Phone: (972) 669-1733  
Fax: (972) 669-1403

### AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

**I HEREBY AUTHORIZE:**  
(Name of person/facility which has information)

Name/Facility: \_\_\_\_\_

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

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**TO SHARE MY HEALTH INFORMATION WITH:**  
(Name of person/facility to receive information)

Name/Facility: \_\_\_\_\_

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

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

### TYPE OF DISCLOSURE (CHECK ALL BOXES THAT APPLY):

1.  Verbal Information/Communication

2.  Copies of records/written information:

Complete Record

Initial Evaluation

Progress Notes

Lab Reports

Written Reports (Letters, Completed Forms, Etc)

Billing Records (Financial Histories Fee Tickets Etc)

Other (Specify) \_\_\_\_\_

### THE PURPOSE OF THIS RELEASE IS:

Continuity Of Care

At The Request Of The Client/Patient/Patient Representative

Other (State Reason) \_\_\_\_\_

I hereby authorize Hope Speaks, PLLC to release/obtain medical information regarding my care and treatment in the manner stated above. I also acknowledge that I have been advised of the notifications and the revocation process as stated on the back of this page.

\_\_\_\_\_  
Printed Name and relationship to patient

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\*\*\* PLEASE BE SURE AND SEE PAGE 2 OF THIS RELEASE \*\*\*

**NOTICE**

Hope Speaks, PLLC and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

I understand that this authorization applies to all records created in the course of my treatment, including information regarding my medical condition and treatment, mental health, alcohol/drug abuse diagnosis and treatment, and communicable disease status, including AIDS/HIV.

In consideration of the release of information by Hope Speaks, PLLC in accordance with this request, I hereby release Hope Speaks, PLLC its agents, servants, and employees from any and all claims, demands, or liability of any kind which might arise out of the release of such information and the effects thereof.

This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.

This Expiration of Authorization: **This authorization remains in affect until we receive your written authorization to revoke this release.** The revocation will take effect when Hope Speaks, PLLC receives it, except to the extent Hope Speaks, PLLC or others have already released the information. You are entitled to receive a copy of this Authorization. Authorization may be revoked at any time.

**The revocation must be in writing, signed by you or your patient representative, and delivered to:**

Hope Speaks, Medical Records Department  
medicalrecords@hopespeaks.com  
1200 E. Collins Blvd., Suite 300  
Richardson, TX. 75081  
Fax: 972) 669-1403

**For Hope Speaks Use Only (check applicable):**

**Records Request was:**

Mailed to address on page 1      Date mailed \_\_\_\_\_      Initials: \_\_\_\_\_

Faxed to number on page 1      Date Faxed \_\_\_\_\_      Initials: \_\_\_\_\_

**Records Released:**

Mailed to address on page 1      Date Mailed \_\_\_\_\_      Initials: \_\_\_\_\_

Faxed to number on page 1      Date Faxed \_\_\_\_\_      Initials: \_\_\_\_\_

Picked up at office      Date Ready \_\_\_\_\_      Initials: \_\_\_\_\_

**Request for Verbal information Only:**

Filed Release in chart      Date filed \_\_\_\_\_      Initials: \_\_\_\_\_

**Records not released:**

Reason: \_\_\_\_\_

Filed Release in chart:      Date filed \_\_\_\_\_      Initials: \_\_\_\_\_