Jeromy Hackney, M.D.
400 W.Medical Center Blvd, Suite 245
Webster, TX 77598
Phone: 281-316-4978
Fax: 281-316-2192

Authorization Request for Medical Records

I hereby authorize use or disclosure of protected health information about me as described below.

I _____ authorize **Dr. Jeromy Hackney** to request any and all medical information from the following persons and or facilities.

Physician/Facility _____

Address: _____

_____

Telephone: _____

Fax: _____

For the purpose of ☐ Continued Care ☐ Attorney/Legal ☐ Personal use ☐ Insurance ☐ Other

Please release the following:

☐ Problem List
☐ Progress Notes
☐ History/Physical Exam
☐ Medication List
☐ Immunization Record
☐ List of Allergies
☐ X-Ray/Imaging Reports
☐ X-Ray Films
☐ Laboratory Results from
☐ EKG Reports
☐ Genetic Testing Information
☐ Other Diagnostic Reports (Specify)

Other (Specify)_____

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke or withdraw this authorization by notifying Texas Urology Specialists desire to revoke it. However I understand that may action already taken in advance of this authorization cannot be reversed and y revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____ _____
Signature of Individual Date of Signature Date of Birth or SS #

Or if applicable

_____ _____ _____
Signature of Guardian Date of Signature Description of Guardian