VANGUARD
INPATIENT PHYSICIANS
Leading Continuum of Care

4645 Sweetwater Blvd, Suite 200, Sugar Land, TX 77479 |4650 FM-1960 Rd West, Suite 101, Houston, TX 77069
Phone: 281-565-1112 Fax: 281-565-1102

Name: _____ **DOB:** _____ **Date:** _____

I hereby authorize:

Physician name:

Address:

Phone number:

Fax number:

To release information to:

Vanguard Inpatient Physicians
Arusha Bavare, M.D.
4645 Sweetwater Blvd, Suite 200, Sugar Land, TX 77479
4650 FM-1960 Rd West, Suite 101, Houston, TX 77069
Phone: 281-565-1112
Fax: 281-565-1102

Purpose of Disclosure:

- □ Continuing Medical Care
- □ Legal
- □ Insurance Claim/Payment
- □ Other (specify):

_____
_____
_____
_____
_____

Information to be released:

- □ H & P/ Initial Evaluation
- □ Consult Notes
- □ Progress Notes
- □ Discharge Summary
- □ Orders
- □ Imaging Reports
- □ Lab/Pathology Reports
- □ Diagnostic Procedure Reports
- □ Other (specify contents and dates)

_____
_____
_____
_____
_____
_____

I specifically authorize the release of information relating to:

- □ Substance abuse (including alcohol/drug use)
- □ Behavioral Health
- □ HIV related information (AIDS related testing)

_____ _____
Signature of Patient or Personal Representative Date

Acknowledgement of understanding:

1. I understand the expiration date of this authorization form is 1 year from the date signed.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand by not authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
5. I understand that I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.

_____ _____
Signature of Patient or Personal Representative Date