LUANN K. HASSAN, M.D., P.A.
6750 N. MACARTHUR BLVD. #211
IRVING, TX. 75039
214-647-1533 * FAX 214-647-1751

AUTHORIZATION TO RELEASE

LUANN K. HASSAN, M.D.

Our Notice of Privacy provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, you may obtain a revised copy upon request. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.

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Signature of Patient or Personal Representative

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Print Name of Patient or Personal Representative

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Date

I authorize________________________________to have access to medical records. ________________________________Relationship