Advanced Surgical of North Texas

Steve Duffy, MD, FACS

Authorization for Disclosure of Medical Information

I authorize the release of my medical records in their entirety for the purpose of examination, diagnosis, and treatment from all previous providers and facilities to:

Advanced Surgical of North Texas
Steve Duffy, MD, FACS
7668 Eldorado Parkway, Suite 200
McKinney, TX 75070

Phone: (972) 439-3753 Fax: (972) 439-3754

I understand that these records may contain administrative information. I specifically consent to the release of information that may relate to HIV or AIDS infection. I authorize you to transmit this information by facsimile and release you from any liability for breach of confidentiality or misdirection of transmission if my records are transmitted by fax.

Printed Name of Patient:_____

Patient Date of Birth:_____ Patient Social Security Number:_____

Signature of Patient or Legal Guardian/Representative: Date:

_____ _____

For Office Use Only Below This Line

For immediate physician review, please fax records:

- ☐ Yes
- ☐ No

Comments:_____

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