SHAWN A. HAYDEN, M.D., Ph.D.
5509 Pleasant Valley Drive, Suite 700
Plano, TX, 75023
214-731-3008 Office
972-608-2026 Fax

RELEASE OF PATIENT INFORMATION

TO: Dr. Shawn A. Hayden

RE:
Patient Name: _____

Date of Birth: _____

From: _____

Phone: _____ Fax: _____

I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose my full and complete protected medical information to Dr. Shawn A. Hayden.

This disclosure should include:

- ☐ Office notes; inpatient, outpatient and emergency room treatments; clinical charts; reports; treatment plans; hospital admission records; discharge summaries.
- ☐ Laboratory results
- ☐ Medication List
- ☐ Imaging Reports (X-Ray; CT Scan; MRI)
- ☐ _____

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein.

_____ _____
Signature of Patient Date