Patient Authorization for Practice to Release Protected Health Information

THIS DOCUMENT CONTAINS IMPORTANT INFORMATION ABOUT YOUR HEALTH INFORMATION. PLEASE READ CAREFULLY.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations, or for other purposes permitted by law. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA).

The above mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

The state of Texas allows the charge of copying your medical records to be sent to certain entities, such as life insurance policies.

- Leave a voicemail regarding appointments? **YES or NO**
- Leave a voicemail regarding lab and pathology results or any other health care issues? **YES or NO**
- Contact you at your place of employment regarding appointments, lab and pathology results or any other health care issues? **YES or NO**
- If you wish to receive email notifications of appointment reminders or notices of due for follow ups please be aware our emails are HIPAA compliant so only potential risk of lost information is if we have an incorrect email. Please verify email is correct with the front desk. **YES or NO**
- If the patient is a minor, I allow the minor, once an established patient, to be seen without the accompaniment of a parent or guardian. **YES or NO**
- Please list **NAME, RELATIONSHIP AND PHONE NUMBER** of any person(s) you give permission for our office to speak with regarding your medical condition. parents of minors and spouses) **YES or NO**

  THEY MUST BE LISTED FOR US TO SPEAK TO THEM.

  Name: Relationship: Phone:

  _____

  _____

  _____

Expiration date of this authorization: ONE YEAR FROM DATE OF SIGNATURE

By signing this form, you authorize the Practice to use and disclose Protected Health Information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

This authorization was signed by:_____

Sign Name – Patient or Representative **(18 and older must sign for themselves)**

Date_____

Print Name – Patient or Representative

Print name _____

Relationship to Patient (if other than patient): _____