AUTHORIZATION FORM FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____
SSN: _____ Previous Name: _____
Physician: _____

I request and authorize: _____
Address: _____
City, State, Zip: _____
Phone/Fax number: _____

To release the medical records of the patient named above to:
Name: _____
Address: _____
City, State, Zip: _____
Phone/Fax number: _____

This protected health information is being used or disclosed for the following purposes (or "at the request of the individual")

_____Company Physical _____Insurance Physical _____Pre-employment Physical
_____At the Request of the Individual _____Other (specify) _____

This authorization shall be in force and effective until the following event and /or date:
_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the Privacy Contact, P.O. Box 120069, Arlington, TX 76012.

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulation.

This practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use of disclosure.

_____ _____
Signature of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority