WOODLANDS FUNCTIONAL FAMILY MEDICINE

AUTHORIZATION FORM
For Release of Protected Health Information

By signing this form, I authorize you to use and disclose the protected health information described below.
Patient Name: _____ DOB: _____
The health information you may release subject to this authorization is as follows:

☐ Complete Medical Records	☐ Laboratory Tests	☐ Prescriptions/Samples
☐ Consultation Reports	☐ Radiology Reports	☐ Speak To Over Phone
☐ Progress Notes	☐ Physicians' Orders	☐ ALL OF THE ABOVE

If **OTHER,** please specify: _____

Release my protected health information the following person(s)/entity:
Name: _____ Relationship to Patient: _____
Street: _____ City: _____ State: ____ Zip: _____ Phone #: _____
This authorization shall be in force and effective indefinitely unless specified below with a term date or term event: _____

☐ **I DO NOT GIVE PERMISSION FOR YOU TO RELEASE MY INFORMATION TO ANYONE.**

I understand that I have the right to revoke this authorization in writing at any time by sending a written notification to the following address:

Woodlands Functional Family Medicine
Phone # 281-298-5476
Fax # 281-298-5241

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 re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The 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 or disclosure.

_____ _____
Signature of Patient or Authorized Representative Date

_____
Print Name of Patient or Authorized Representative