Huntsville Pediatric & Adult Medicine
ASSOCIATES

*We treat children **and** adults*

David A. Prier, M.D. John D. Knight, M.D. Gregory C. McKeever, M.D. Victor K. Hsiao, M.D.
Glenda J. Read, M.D. Lowell Rollins, M.D. Jayne R. Schulte, M.D. Patricia O'Brien, FNP

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Other Names Used: _____

1. I authorize the use or disclosure of the above named individual's health information as described below from the following individual or organization:

   Physician or Facility Name: _____**Huntsville Pediatric and Adult Medicine Associates** _____

   Address: ____**100 Medical Center Parkway Ste. 1000**_____

   City, State, and Zip Code: __**Huntsville, Texas 77340-4966**_____

   Phone Number: __**936-295-8000**_____ Fax Number: __**936-439-1169**_____

2. The type and amount of information to be used or disclosed is as follows:

   - ☐ Entire record
   - ☐ Immunization record
   - ☐ Growth charts
   - ☐ Consultation reports - From (doctor's names) _____
   - ☐ Other (please specify) _____
   - ☐ Physician's progress notes
   - ☐ Laboratory results
   - ☐ X-ray and imaging reports

3. I understand that the information in my health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be disclosed to and used by the following individual or organization

   Physician or Facility Name: _____

   Address: _____

   City, State, and Zip Code: _____

   Phone Number: _____ Fax Number: _____

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the administrator of Huntsville Pediatric and Adult Medicine Associates. I understand that the revocation will not apply to information that has already been released in respo9nse to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the administrator of Huntsville Pediatric and Adult Medicine Associates.

_____ _____

Signature of patient or Legal Representative Date

_____ _____

If signed by Legal Representative, Relationship to Patient Signature of Witness