

Huntsville Pediatric & Adult Medicine
A S S O C I A T E S

*We treat children **and** adults*

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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: _____

Address: _____

City, State, and Zip Code: _____

Phone Number: _____ Fax Number: _____

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

- | | |
|---|---|
| <input type="checkbox"/> Entire record | <input type="checkbox"/> Physician's progress notes |
| <input type="checkbox"/> Immunization record | <input type="checkbox"/> Laboratory results |
| <input type="checkbox"/> Growth charts | <input type="checkbox"/> X-ray and imaging reports |
| <input type="checkbox"/> Consultation reports - From (doctor's names) _____ | |
| <input type="checkbox"/> Other (please specify) _____ | |

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: 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

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 response 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