RHEUMATOLOGY OF THE WOODLANDS

MEDICAL RECORD RELEASE FORM

AUTHORIZATION TO RELEASE PROTECTED HEATH INFORMATION

JOHNSON PH: 281-297-6476 | **PARKE** PH: 281-297-7625 | FX: 281-297-6425

By signing this form, I authorize you to use and disclose the protected health information described below.

Patient Name: _____ Date of Birth: _____

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 Over the Phone
☐ Progress Notes	☐ Physician Orders	☐ All the Above

If **OTHER**, please specify: _____

Release my protected health information to/from the following person(s)/entity:

Name: _____

Address: _____

Phone: _____ Fax: _____

This authorization shall be in force and effective indefinitely, unless specified below with a term date or term event:

I understand that I have the right to revoke this authorization in writing at any time by sending a written notification to the following clinic address: 9323 Pinecroft Dr. Ste. 200, The Woodlands, TX 77380, Fax # 832-299-6958.

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 police 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

_____

Printed Name of Patient or Authorized Representative