RELEASE OF PROTECTED HEALTH INFORMATION

TO DESIGNATED REPRESENTATIVE(S) PATIENT AUTHORIZATION

I, _____, give my authorization to release my protected health information including RESULTS OF MY LABORATORY TESTS, X-RAY AND/OR OTHER TEST RESULTS to the following designated representatives ***in the event that I am unable to be contacted first***:

PATIENT INITIALS	NAME & PHONE NUMBER
	May be left on **my** cellphone voicemail #
	May be left on **my** home answering machine #
	My spouse
	My child
	Other
	Other
	Personal Rep
	MAY NOT LEAVE VOICEMAILS, AND MAY NOT BE GIVEN TO ANYONE OTHER THAN MYSELF.

_____ _____

(Patient/Guardian) Signature Date

_____ _____

Witness Date

As a patient, you have the right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Rheumatology of the Woodlands must receive the revocation in writing. The revocation must include 1) Patient name, address and date of birth, 2) Patient's desire to revoke authorization, and 3) the date of revocation and the patient's signature. All revocations must be sent in writing to Dr. Frank Parke or Dr. Randall Johnson, 9323 Pinecroft Dr. Suite 200, The Woodlands, TX 77380 or faxed to Dr. Parke 281-651-4365 // Dr. Johnson 281-297-6425. Revocation will not be considered effective until received by our office.