

**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:

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

Name: _____

Street: _____

City: _____ **State:** _____ **Zip:** _____

The reasons or purposes for this release of information are as follows:

This authorization shall be in force and effective until the following event and/or date:

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

Chuck Moses	(817) 277-2221 ext. 280	fax (817) 459-5253
Pam Steele	(972) 864-0252 ext. 504	fax (972) 278-2534

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 redisclosure 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 Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority