HOUSTON Methodist
PRIMARY CARE GROUP

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I. PATIENT INFORMATION:

Patient Name:		
Date of Birth:		
Patient Mailing Address:		
City:	State:	Zip:
Work #:	Home #:	Cell #:
My family physician is:		

II. INFORMATION TO BE DISCLOSED:

I authorize _____to disclose my health information as follows, for service dates: _____:

- ☐ All paper chart records
- ☐ Entire medical record/outpatient clinical record
- ☐ History and physical(s)
- ☐ Operative report(s)
- ☐ Discharge summary(ies)
- ☐ Films and pictures
- ☐ All electronic medical records
- ☐ Laboratory results
- ☐ Radiology and imaging reports
- ☐ Pathology reports
- ☐ Other test results: _____
- ☐ Other: _____

I understand that information used or disclosed pursuant to this authorization form may include information relating to Human Immunodeficiency Virus (HIV), or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

III. INFORMATION IS TO BE DISCLOSED TO/FROM:

Disclose to:	Disclose from:

IV. PURPOSE OF USE OR DISCLOSURE: _____

V. I authorize the disclosure of health information as described above. I understand:

- This authorization is valid for 180 days unless otherwise stated here: _____
- A photocopy or fax of this authorization is as valid as the original.
- I may revoke this authorization at any time by submitting a revocation in writing to Houston Methodist Primary Care Group.
- If I revoke this authorization, the revocation will not apply to information that has already been released in good faith before the revocation was received.
- Treatment or payment may not be conditioned on my completion of this authorization form.
- Information disclosed pursuant to this authorization may be redisclosed by the recipient and no longer protected by the federal privacy laws.
- I understand that Houston Methodist may disclose my Protected Health Information electronically or by other means

_____ _____

Signature of Patient or Qualified Personal Representative* **Date**

*If signed by a Qualified Personal Representative, the following must be completed:

Printed name of Qualified Personal Representative: _____

Legal Documentation showing Authority to Act on Behalf of the Patient: _____

(Example: Guardian of Patient, Executor of Estate)