Deer Park Family Clinic, P.A.
2910 Center Street
Deer Park, Texas 77536
(281) 479-5941 Fax (281) 479-8459

PATIENT AUTHORIZATION FORM
RELEASE OF MEDICAL INFORMATION

Patient Name:_____DOB:_____

SS#:_____DPFC ID#:_____

Address:_____Telephone:_____

I hereby authorize **Deer Park Family Clinic, P.A.** to release information from the medical records of

_____ to:
Patient Name

Name or Facility:_____

Address: _____

Phone:_____ **Fax**:_____

Description of the information to be used or disclosed:

_____

_____

_____

Information regarding HIV, chemical dependency, or sexually transmitted diseases _____can ____cannot be released.

This information is being requested for the following purpose:

_____

_____

This authorization shall remain in effect from the date signed below until _____(expiration date or event). Otherwise, this authorization is valid until the 180th day after the date it is signed, not to exceed 24 months, or unless it is revoked.

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment.

_____ Date:_____
Signature of Patient/Parent/Conservator/Guardian

_____
Relationship to Patient

Fees/ charges will comply with all laws and regulations applicable to release of Protected Health Information. Payment is due at time of release.

COMPLETED BY: **_____** ***DATE:*****_____** ***MAIL OR FAX:*****_____**