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

PATIENT AUTHORIZATION FORM

RELEASE TO DEER PARK FAMILY CLINIC, P.A.

Patient Name:_____DOB:_____

SS#:_____DPFC ID#:_____

Address:_____Telephone:_____

I hereby authorize:

_____

Facility Name / Physician Name, Address & Phone Number

to release information from the medical records of _____to:

Patient Name

Deer Park Family Clinic, P.A.
2910 Center Street
Deer Park, Texas 77536-4199
_____Andrew S. Metz, D.O.
_____Donald R. Metz, D.O.

Description of the information to be used or disclosed:

_____

_____

_____

Information regarding HIV, chemical dependency, or sexually transmitted diseases_____can_____cannot be disclosed.

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.