

AUTHORIZATION TO DISCLOSE MEDICAL/FINANCIAL INFORMATION

Date _____

Re _____

(Name of Patient)

_____ (Date of Birth)

Address Line 1

Address Line 2

New federal privacy guidelines, HIPAA, prevent this office from disclosing protected health information (“PHI”) to anyone other than the patient. By signing this form, you are allowing us to communicate with designated individuals regarding your medical and financial record with this facility.

I, the undersigned, hereby authorize Medicine Associates of North Texas – HEB to disclose PHI from my medical or financial record to the following person/people:

Name: _____

Relationship: _____

Type of Information: (Circle One) Medical Financial Both

Name: _____

Relationship: _____

Type of Information: (Circle One) Medical Financial Both

Name: _____

Relationship: _____

Type of Information: (Circle One) Medical Financial Both

ADDITIONAL PERSONS MAY BE LISTED ON THE OTHER SIDE IF NECESSARY

This authorization is given freely with the understanding that

- I may revoke this authorization in writing at any time but not retroactively
- The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability to disclosure o the information I have authorized.

Patient’s printed name

Patient’s Signature

Date