HIPAA Authorization for Release of Information Form

I hereby authorize use or disclosure of protected health information about me as described below.

RECORDS ON (PATIENT NAME)_____(DOB)_____

The following specific person or class of persons or facility is authorized to make the requested use or disclosure:

RECORDS MAILED FROM: _____

_____

_____

The following person or class of persons may receive disclosure of protected health information about me.

RECORDS MAILED TO:
Ph. 281-297-7625
Fax. 936-760-8534

Dr. Frank Parke
9201 Pinecroft
The Woodlands, Texas 77380

Specific description of information to be released (must include date(s) of service):

ALL RECORDS

The information to be released will be used for the purpose described below:

CONTINUED CARE

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke or withdraw this authorization by notifying GHPMA in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

This authorization will expire on _____, or 1 (one) year after the date of said authorization.

***THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING*.**

Signature of Individual	Date of Signature	Date of Birth or SS Number

-- OR, if applicable --

Signature of Guardian	Date of Signature	Description of Guardian's or Personal Representative's Authority to Act for the Patient

A copy of this completed, signed and dated form must be given to the Individual or person signing on the Individual's behalf.