AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

_____ I authorize M. J. Whiteley, D.O. and associates, d.b.a. Tomball Familicare to **release my records to**:

_____ I authorize M. J. Whiteley, D.O. and associates, d.b.a. Tomball Familicare to **receive records from**:

_____

Person or Organization** Full Address**

_____

Phone Number Fax Number (if applicable)

Information/copies form the medical records on:

_____

Patient** Date of Birth** Social Security Number

_____

Date(s) of Service If all dates of service, write "all"

INFORMATION TO BE RELEASED: ( ) Any and All Records**

( )**All** Medical Records ( )Radiology reports ( )HIV and AIDS information
( )Billing Records ( )Drug/Alcohol information ( )Other_____
( )History and Physical ( )Psychiatric information
( )Consultations ( )Lab reports
( )Operative Reports ( )Pathology reports
( )Sexually transmitted disease "STD" information

This information is being released for the following purpose:
( )Continued Care ( )Attorney/Litigation ( )Insurance ( )Disability Services ( )Other_____

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been take in reliance on it and that in any event this authorization shall expire (180) days form the date of my signature, unless specified in writing here:_____

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulation.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you form records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose.
FOR PATIENT RECORD APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2

_____ _____
Signature of Patient or Legal Authorized Representative** **Date****

_____
Relationship to the Patient

_____
Print Name of Legally Authorized Representative**

_____
Witness- Printed Name/Signature**

_____
Patient or Legally Authorized Representative Driver's License /ID#_**

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