AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____Date of Birth: _____

Address: _____ City: _____State: _____ Zip_____

By signing this form, I authorize the party listed below to release and/or disclose my protected health information:

Name: _____

Address: _____

City: _____State: _____ Zip: _____

To: The DeWitt Clinic, PA
304 Medic Ln Ste B
Alvin, TX 77511
Telephone: 281-331-2062 **Fax #: 281-331-2063**

The reason for this disclosure is: _____

My medical records may include information regarding diagnosis and treatment of drugs, alcohol, acquired immune deficiency syndrome (AIDS), or psychiatric disorders. The information to be release includes:

___ Entire Record ____History & Physical ____Discharge summary
___ Operative reports ____Consult Reports ____ Progress notes
___ Pathology reports ____Radiology reports ____ Laboratory results
___ Other: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notice to The DeWitt Clinic, PA.

I understand that the information used to disclose pursuant to this authorization may be subject to redisclosure by the recipient and may not be protected by federal HIPAA privacy regulations.

The DeWitt Clinic will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

_____ _____
PATIENT, GUARDIAN, OR LEGAL REPRESENTATIVE DATE

_____ _____
WITNESS DATE