HOUSTON CENTER FOR INFECTIOUS DISEASES, P.A.

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

I authorize **Houston Center for Infectious Diseases, P.A.** and/or the entity below to use / disclose my healthcare information as identified below.

Patient Name: _____ Date of Birth: _____ Date: _____

Medical records requested from:

Name _____

Phone # _____ Fax # _____

Address _____

Medical records sent to:

Name _____

Phone # _____ Fax # _____

Address _____

Record Transfer for the following purpose:

[ ] Patient's Request [ ] Continued Medical Care [ ] Insurance [ ] Other

By checking the spaces below, I specifically authorize the use or disclosure of the following health information, if such information exists:

[ ] Entire Record [ ] Hospital Record Information [ ] Lab Results [ ] Progress Notes [ ] Other

***The following items must be initialed to be included in the use or disclosure of other health information:**

_____ Drug/alcohol related records
_____ Genetic testing related records
_____ HIV/AIDS related records
_____ Mental health related records

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to Houston Center for Infectious Diseases, P.A. Unless revoked earlier, this authorization will expire 180 days from the date of signing. At patient's request, a signed copy of this authorization will be provided to you.

_____ _____
Signature of Patient or Legal Guardian Date:

_____ _____
Print Name of Patient or Legal Guardian Date: