deAyala OB/GYN Associates of Houston, PLLC

902 Frostwood Dr. Suite 108, Houston, TX. 77024
Phone (713) 827-4744
Fax (713) 827-4766

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient: _____ Date of Birth: _____/_____/_____
First Name Initial Last Name

Phone #: _____ Email Address (optional) _____

I hereby authorize: Deayala OB/GYN Associates of Houston
902 Frostwood Dr. Ste. 108 Houston TX 77024
Phone (713) 827-4744 Fax (713) 827-4766

☐ To Disclose to ☐ To Receive from

Person/Organization Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____

Information Requested for the following purpose:

__ Diagnosis and Treatment __ Coordination of Care __ Insurance __ Personal Use

__ Other _____

Information to be released or exchanged include (check all that apply)

__ Entire Medical Records __History and physical __ Behavioral/Physical Health Treatment Records

__ Laboratory Reports __ Medication Report __ Radiology Reports __ Operative Reports __ Prenatal Records

☐ I authorize to disclose information containing HIV, STD or Behavioral Health, or Drug and Alcohol Abuse Treatment.

Patient Signature: _____ Date: _____

I understand that this Authorization is effective for a period of 60 days from the date of signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized to release the information. If applicable, specify other expiration date/even here: __/__/__.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my consent or permission, including disclosures to covered entities as provides by Texas Health & Safety Code 181.154 (c) and/or 45 C.F.R. 164.502 (a) (1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. I also understand I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.