CONROE FAMILY DOCTOR
caring for your family as we would our own

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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 (PLEASE CIRCLE ONE) FROM OR TO:
Conroe Family Doctor, PLLC, 1020 Riverwood Ct., Suite 100, Conroe, TX 77304
Ph: 936-441-2012 Fax: 936-494-4012

The following person or class of persons may receive disclosure of protected health information about me.
RECORDS MAILED (PLEASE CIRCLE ONE) FROM OR TO:

Entity Name:_____**Ph:**_____**Fax**_____

Address_____**City**_____**State**_____

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

The information to be released will be used for the purpose described below: To facilitate patient 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 **Conroe Family Doctor, PLLC** 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 I sign the authorization.
This authorization will expire 1 (one) year after the date of said authorization.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

Signature of Individual_____Date:_____Date of Birth or SS Number_____

-- OR, if applicable --

Signature of Guardian_____Date:_____

_____
Description of Guardian's Personal Representative's Authority to Act for the Individual