

# Authorization Form For Release of Protected Health Information

By signing this form, I authorize you to use and disclose the protected health information described below.

**Patient Name:** \_\_\_\_\_

**The health information you may release subject to this authorization is as follows:**

---

---

---

**Release my protected health information to the following person(s)/entity:**

**Name:** \_\_\_\_\_

**Street:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**The reasons or purposes for this release of information are as follows:**

---

---

---

**This authorization shall be in force and effective until the following event and/or date:**

---

**I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person at the practice:**

**Contact:** \_\_\_\_\_

**414 Navarro, Ste. 1407 San Antonio, Tx. 78205  
(210) 277-6255 Fax (210) 277-6256**

**I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.**

**I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.**

**The practice 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.**

---

**Signature of Patient or Personal Representative**

---

**Date**

---

**Name of Patient or Personal Representative**

---

**Description of Personal Representative's Authority**