PRIMARY CARE OF
Health First SOUTHERN TEXAS

Patient Authorization for Release of Protected Health Information

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

Address:_____SS#: ----------_____

I hereby authorize the physician / practice (Disclosing Physician/Practice) listed below to release my Protected Health Information (information contained in my medical records) to PRIMARY CARE OF SOUTHERN TEXAS and affiliated healthcare providers.

Disclosing Physician / Practice:_____Phone: (_____) --------_____

Description of Information to be disclosed:

_____ Complete Medical Record
_____ Chest X-Rays
_____ Echocardiograms
_____ Office Notes
_____ Labs Reports / Tests
_____ Nuclear Stress Test
_____ EKG Test / Results
_____ Holter Monitor Results

Protected Health Information to be disclosed to:

PRIMARY CARE OF SOUTHERN TEXAS
Attn: MEDICAL RECORDS
27160 US-290, Cypress, TX 77429, United States
PHONE: (713) 673-8774 FAX: (713) 673-8044

Purpose of Disclosure:

_____ Continuing Care
_____ Referral to Specialist
_____Change of Doctor
_____ Other: _____

I understand the following:

1). I may revoke this authorization at any time by providing written notice to PRIMARY CARE OF SOUTHERN TEXAS.
2). I may not be able to revoke this authorization once the office has utilized the information received, or if the authorization was obtained as a condition of obtaining insurance coverage.
3). PRIMARY CARE OF SOUTHERN TEXAS will not condition treatment or payment based upon my signing of thisAuthorization.
4). The information disclosed by this authorization may be subject to re-disclosure by PRIMARY CARE OF SOUTHERN TEXAS. and no longer protected by Federal Law.
5). I have reviewed this Authorization and understand its purpose and intent
6). This Authorization is valid until or unless I submit in writing a request of revocation to the practice.

_____ _____ _____
Patient Signature Date Name (if other than Patient)