The M.D.'s Weight & Wellness Center, P. A.

200 River Pointe, Suite 115 * Conroe, TX 77304 * Phone (936) 756-8446 * Fax (936) 756-8472

Authorization for Release of Protected Health Information (PHI)

Patient Name | Date of Birth

Address | Telephone Number

I hereby authorize The M.D.'s Weight & Wellness Center, P.A., 200 River Pointe, Suite 115, Conroe, TX 77304, Phone (936) 756-8446, Fax: 936-756-8472 to disclose the above-named individual's health information.

Date(s) of Service Requested (if known) or Provider: _____

Description of information to be released: (check all that apply)

_____ Progress Notes
_____ EKG
_____ Consultations
_____ Most Recent History and Physical
_____ Other _____
_____ Laboratory Reports

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), genetic testing or screening, behavioral or mental health, alcohol/drug (substance) abuse o any such related information.

This information may be disclosed to and used by the following individual or organization (receiving the Information)

Name (facility receiving information) Address City State Zip

Telephone Number Fax Number

Description of the purpose of the use and/or disclose: (check one)

_____ Continuing Care
_____ Second Opinion
_____ Emergency Acute Care
_____ Consultation
_____ Insurance
_____ Social Security/Disability (provide copy of SSA Letter)
_____ Legal Purposes
_____ Personal Use
_____ Other: Please Describe: _____

I understand that this authorization is voluntary and I may refuse this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I may inspect or copy the information to be used or disclosed and that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations. The M.D.'s Weight & Wellness Center, P.A. may charge a processing fee for this service. This authorization will expire, by law, 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until _____ (date).

I further understand that I may revoke this authorization at any time by notifying The M.D.'s Weight & Wellness Center, P. A.. If I revoke this authorization, I must do so in writing and the written revocation must be signed and dated with a date that is later than the date of the authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____
Signature of Patient or Patient's Representative | Date

_____
Printed name of Patient or Patient's Representative

_____ or _____
Relationship to Patient | Legal Authority (attach supporting documentation)