Authorization for Disclosure of Protected Health Information

Patient Name: ___________________________ Date of Birth: ___________
Address: _______________________________ SS#: ___________________
____

I HEREBY AUTHORIZE (name of releasing entity):

____
NAME OF ENTITY
____
STREET ADDRESS
____
CITY, STATE, ZIP CODE
____
PHONE #
____
FAX #

TO DISCLOSE MY PROTECTED HEALTH INFORMATION, AS DESCRIBED BELOW TO (name of receiving entity):

Todd J. Swick, MD, PA
7500 San Felipe, Suite 525
Houston, TX 77063
Phone: 713-465-9282
Fax: 713-465-9248

INFORMATION TO BE RELEASED:

__Medical Records
__Progress Notes
__X-ray Reports
__Laboratory Results
__Mental Health
__Sexual Transmitted Disease
__HIV test results*
__Alcoholism/ Drug Abuse
__Surgical Reports
__Developmental Disabilities
__Prescriptions
__Consultations
__Allergy Records
__Polysomnogram Test
__Multiple Sleep Latency Test
__Maintenance of Wakefulness Test
__Other (please specify):____
____

a list of the statutory exceptions for release of HIV test results without consent is available

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standard and my health information might be redisclosed without obtaining my authorization. I UNDERSTAND THAT I HAVE RIGHTS TO:

* RECEIVE A COPY OF THIS AUTHORIZATION
* REFUSE TO SIGN THIS AUTHORIZATION and that treatment, payment, enrollment in a health plan or eligibility for health are benefits may not be contingent on my signing this authorization
* REVOKE THIS AUTHORIZATION, except to the extent that the person(s) and or organization listed above already made in reference to this authorization

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL THE FOLLOWING DATES:

X ____________________________ _______________
Signature of patient (or legal representative) Date

If signed by a legal respresentative:

X ____________________________ _______________
Relationship to patient Date