Authorization Form for Release of Protected Health Information

By signing this form, I authorize you to disclose protected health information described below by telephone, fax or mail.

Patient Name: _____

The information you may release subject to this authorization is as follows: (Example: appointment date/time, explanation of diagnosis and /or procedures, billing information, etc.)

_____

_____

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

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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 authorizatiot1; in writing, at any time by sending a written notification to the following person at the practice:

Fort Worth Perinatal Associates, Office Manager
1250 8th Avenue, Suite 570
Fort Worth, Texas 76104
Ph. 817-332-6667, Fax 817-546-0946

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 re-disclosure by the recipient and may no longer be protected by federal HIPPA privacy regulations.

The practice will not condition my treatment, payment, and enrolment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

_____

Patient Signature Date