Katy Medical Center
948 S. Fry Road
Katy, Texas 77450
Phone: (281) 398-7778 Fax: (281) 398-7779

PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Katy Medical Center to use/disclose my individually identifiable health information as described below. I understand that the information I authorize another person or entity to receive may be re-disclosed by them, and may no longer be protected by federal privacy regulations. This authorization is for the practice to:

RELEASE TO:	OBTAIN FROM:
NAME:	NAME:
ADDRESS:	ADDRESS:
CITY, STATE, ZIP:	CITY, STATE, ZIP:
PHONE:	PHONE:
FAX:	FAX:

Note: HIPPA allows a maximum of 30 days to prepare copies of your records. You may be charged a fee for duplication of records which will be clarified with you prior to preparing copies.

Please mail all records to:
948 S. Fry Road, Katy, Texas 77450 Attn: Medical Records

The information to be used or disclosed is specifically described below:
□ Office Notes □ Entire Record □ Diagnostics/Labs □ Other
Purpose of disclosure:
□ Attorney/Legal □ Insurance/Reimbursement □ Personal Use □ Continued Medical Care
□ Other _____

I understand that this authorization is voluntary and that I may refuse to sign it. I understand that, if I refuse to sign this authorization, my refusal will not affect my ability to obtain treatment. I understand that I may revoke this authorization at any time by notifying in writing the Privacy Officer at Katy Medical Center 948 S. Fry Road, Katy, Texas, 77450. However, the revocation will not be valid to the extent that the practice has taken action in reliance on this authorization or to the extent this authorization is executed as a condition for obtaining insurance coverage. My physician will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

This authorization expires on: _____

Patient Name: _____
Date of Birth: _____
Phone: _____
Address: _____
City, State, Zip: _____

_____
Signature of Patient Date

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FOR MEDICAL RECORD USE ONLY:

Request completed on: _____ by: _____