RHEUMATOLOGY CENTER OF HOUSTON
www.rheumatologycenterofhouston.com

1200 Binz St, Suite 1495 Houston, TX 77004 Tel: 713-640-5477 Fax: 713-640-5872

General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____Date of Birth _____
Address: _____
Phone: _____SSN: _____

I authorize the custodian of records: _____
to disclose/release the following information* (check all applicable):

- ☐ All records
- ☐ Laboratory/pathology records
- ☐ X-ray/radiology records
- ☐ Billing records
- ☐ Progress Notes
- ☐ Pharmacy/prescription records
- ☐ Other (describe specifically) _____

*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

These records are for services provided on the following date(s): _____

Please send the records listed above to (use additional sheets if necessary):

Name:	__Jacqueline Vo, MD_____	Name:	_____
Address:	__1200 Binz St, Suite 1495_____	Address:	_____
	__Houston, TX 77004_____		_____
Fax:	__713-640-5872_____	Fax:	_____

The information may be used/disclosed for each of the following purposes:

- ☐ At my request (only the patient can check this box)
- ☐ For my health care
- ☐ For payment/insurance
- ☐ For employment purposes
- ☐ Other: _____ _____

This authorization shall be valid for 120 days from the date of signature. The patient can revoke this authorization in writing at any time prior to the expiration date.

The patient agrees that a photocopy of this authorization may be considered valid.
____ Yes _____ No

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____	_____
Signature of patient (or patient's personal representative)	Date
_____	_____
Printed name of patient representative	Representative's authority to sign for patient, (ie parent, guardian, power of attorney, healthcare, executor)