RED RIVER FAMILY PRACTICE, LLP

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AUTHORIZATION FORM

Regarding the Use & Disclosure of Health Information

I hereby authorize the following use or disclosure of my health information:

Entity or Person Authorized to ***Make*** the Use/Disclosure: P: FAX:

DR NAME:

In the event that (full Name of Your Practice) "your practice" is entered in the space above, I understand that I may inspect or copy the health information to be used or disclosed. I further understand that the health information identified in this Authorization may be subject to redisclosure by the recipient and therefore may no longer be protected by this rule. The following also needs to be completed:

Will your practice be reimbursed, directly or indirectly, for the Use/Disclosure? ___Yes ___No

Entity or Person ***TO WHOM*** the Use/Disclosure should be made:

RED RIVER FAMILY PRACTICE
900 E 30TH ST SUITE 300
AUSTIN, TEXAS 78705
(512)476-6555

X Description of Information to be Used/Disclosed:

Purpose of the Use/Disclosure:

I understand that I may refuse to sign this authorization and that treatment and payment cannot be conditioned upon my completion of this form. I understand that this authorization may be revoked in writing except to the extent that your practice has acted in reliance thereon.

X ***Name***: PRINT NAME X ***DOB***:

X ***SSN***:

X **Signature** X **Date**

If this authorization is being signed by a personal representative, describe the representative's authority to act for the individual:

MAKE A COPY OF THIS SIGNED AUTHORIZATION AND PROVIDE TO THE PATIENT