CONROE ENDOCRINOLOGY CENTER
150 PINE FOREST DR. SUITE 103 SHENANDOAH, TX 77384
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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Effective 11/01/2016

I hereby authorize the use or disclosure of the named individual's health information as described below:

Patient Name: _____

Date of Birth: ___/___/_____ (mm/dd/yyyy)

Information may be released by or to Conroe Endocrinology Center (circle one): Yes No

Information to be Released within Treatment Dates: _____ to _____

Information may be released to or by the following individual or organization:

Name: _____Phone: _____

Name: _____Phone: _____

Name: _____Phone: _____

(Requests for release of PHI must be specific. Please check the following below.)

- o Referrals
- o H&P
- o Medical Profile
- o Laboratory Reports/ X-ray and other imaging
- o All Medical Record

DO NOT Release Information Relating to:

- o HIV/AIDS diagnosis/treatment
- o Alcohol/Drug diagnosis/treatment
- o Other : _____

I understand that the information I am authorizing for disclosure/release to the above named entity may be subject to re-disclose and no longer be protected by the privacy rule.
Conroe Endocrinology Center will not withhold treatment, benefits, or payment processing if you refuse to sign this authorization. This authorization shall remain valid until otherwise changed or modified by Conroe Endocrinology or myself.
Additionally, I understand that I may revoke this authorization at any time by submitting a request in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
Patient Signature/Legal Representative:

_____ Date: _____