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Houston, Texas 77098
Phone: 713-528-0426
Fax: 713-942-0542

Angela E. Partida, M.D.

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Patient Name: _____ **Date of Birth:** _____

This authorization gives **Dr. Angela E. Partida** your permission to acquire, use or release specified health information for treatment, payment, and health care operations. I authorize and request the disclosure of all protected information for the purpose of review and evaluation. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

***Initial each box to indicate whether you consent to the release of the health records described**

☐ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, telephone messages, and records received by other medical providers.

☐ All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period _____ to _____.

☐ I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

☐ Other:_____
(ie: letter for work, request for school accommodations, treatment summary)

☐ This protected health information is disclosed for the following purposes:

_____

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records, the restrictions of which have been specifically considered and expressly waived. You are authorized to release/obtain the above records to/from the following:

Name: _____

Address: _____

Phone: _____ Fax: _____

I understand the following:

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization maybe re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____
Signature of Patient or Legally Authorized Representative Date

_____
Name and Relationship of Legally Authorized Representative to Patient