

RED RIVER FAMILY PRACTICE, LLP

Michael E. Killian, M.D.

Cynthia Brinson, M.D.

J. Eric Lambeth, M.D.

Gary L. Wertz, M.D.

Mary Bartz, M.D.

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: _____

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

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:

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.

Name: _____ DOB: _____

SSN: _____

Signature

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