MARCIA M. LAVIAGE, PHD

2503 Robinhood St, Suite 145 Houston, TX 77005
Phone: 713-818-8187

AUTHORIZATION FOR USE of PROTECTED HEALTH INFORMATION

Please read this entire form before signing and complete all sections that apply to your decisions relating to the disclosure of protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law.

Patient

Patient Name: _____ Date of Birth:_____

Address:_____ City/State/ZIP:_____

Contact Phone:_____

Release /Request

I authorize INSERT NAME HERE, to:

□ Release To □ Request From □ Mutually Exchange Information with

Person/Organization:_____

Address/Location:_____

Phone:_____ Relationship to Patient:_____

Form of Release of Information

□ Paper
□ Electronic
□ Phone contact
□ Other:

Information to Release

□ Diagnostic Impressions, Clinical Treatment & Summary
□ Complete Treatment Records, including Progress Notes
□ Other:

Included Dates :_____ to _____

Purpose

□ Continuity of care
□ Legal
□ Insurance
□ Other:

Expiration/Revocation

This authorization is valid until the earlier occurrence of the death of the individual, the individual reaching the age of majority, permission is withdrawn, or this specified date:

I understand that I can revoke or cancel this authorization at any time in writing, signed by me or on my behalf and delivered to INSERT NAME HERE If I revoke this authorization, the revocation will not have any effect on any actions taken prior to receiving revocation.

Fees

A fee of $20 for the first 20 pages, and 50¢ per page for each additional page plus the actual cost of postage/delivery may apply.

Notice of Rights

*I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

*I understand that I may receive a copy of this completed form upon request.

*I understand there may be a cost for this copy or other services related to the release of medical records.

*I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

Signature

_____ _____
Signature of Patient, Parent, or Legal Representative Date of Signature

_____ _____
Printed Name Relationship to Patient