AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION – ESTABLISHED PATIENT

Patient Name (please print)	Date of Birth	Patient Name	Date of Birth
Patient Name	Date of Birth	Patient Name	Date of Birth

I, _____, hereby authorize the use and/or disclosure of protected health
(parent/guardian/patient)
information (PHI).

TO: Dr.'s Name/Person/Organization: _____
Address: _____
City, State, Zip _____
Telephone: _____ Fax No.: _____

FROM: ____ Raymond A. Kahn, M.D. _____Paige Garrison, M.D. _____Sara Goldstein, D.O.

5819 Highway 6 S, Suite 330
Missouri City, TX 77459
(281) 499-6300
Fax (281) 499-7180

I specifically authorize the use and disclosure of the following PHI:

- ☐ Dates of Service _____
- ☐ Consult Records
- ☐ Laboratory Reports
- ☐ ADHD Reports
- ☐ Immunization Record
- ☐ Radiology Reports
- ☐ Entire Medical Record

I understand that the information in my record may include information relating to sexually transmitted diseases which may include, but are not limited to diseases such as hepatitis, syphilis, gonorrhea, the human immunodeficiency virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information will be used for:

- ☐ Consultation
- ☐ Insurance
- ☐ Personal
- ☐ Other: _____
- ☐ Continuing Care
- ☐ Legal
- ☐ Second Opinion

I understand that I can revoke or terminate this authorization by submitting a written revocation to the address listed below except to the extent that disclosure made in good faith has already occurred in reliance on this consent. Without prior revocation, this authorization will automatically expire six months from this date. If I have questions about disclosure of my health information, I can contact Laura Eaton, privacy officer, at (281) 499-6300.

If neither federal nor Texas privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Texas privacy law.

FEES: I understand and agree that there may be costs associated with this request in compliance with State and Federal Copying laws. _____*(PLEASE INITIAL)*

Signature of Patient or Legal Representative	Printed Name
Relationship to Patient (If Legal Representative)	Date

We will no longer be able to accept written requests from another office that is not HIPAA compliant. In this case, we will need to send you a copy of our request form and ask that it be filled out and signed.

Date request completed _____ **By:** _____ **4/8/2022 10:17 AM**