Care Physicians, P.A.
6655 Travis, Suite 500
Houston, TX 77030
M: 713-400-2900
F: 713-400-2939

Care Physicians, P.A.
17270 Red Oak Drive, Suite 170
Houston, TX 77090
M: 281-453-4300
F: 281-453-4315

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE AND SIGN

I. I, _____ hereby voluntarily authorize the disclosure of information from my health record.
Name of Patient

II. The information is to be disclosed by: *Care Physicians, P.A., 6655 Travis, Ste 500, Houston, TX 77030.*
Care Physicians, P.A.,17270 Red Oak Drive, Suite 170, Houston, TX 77090.

And is to be provided to: ☐All Listed Below

☐West Houston Surgical Associates, 12121 Richmond, Ste. 312, Houston, TX 77082
Dr. Steven Thomas and Dr. Christopher Reilly

☐Minimally Invasive Surgeons of Texas, 6700 W. Loop S, Ste. 500, Bellaire, TX 77401
Dr. Erik Wilson, Dr. Todd Wilson, Dr. Brad Snyder, Dr. Michael Trahan,
Dr. Amanada Parker, Dr. Vinnie Bajwa, and Dr. Sheilendra Mehta

☐Dr. Kenneth Hollis, 11914 Astoria Blvd Houston, TX 77089
☐Dr. Richard Wilkenfeld, 8000 Hwy 242, Suite 123, Conroe, TX 77385
☐Comprehensive Sleep Medicine, 17080 Dallas Parkway, Dallas, TX 75248
☐Psy-Med, 8140 Walnut Hill Lane, Dallas, TX 75231
☐Apnix, 4003-B Bellaire Boulevard, Houston, TX 77025

☐Other – Please Provide:

Name & Address of Primary Care Physician:
_____
_____
_____

Name & Address of Person/Organization/Facility:
_____
_____
_____

III. The purpose or need for this disclosure is:
☐Further Medical Care ☐Attorney ☐School ☐Research
☐Personal Use ☐Insurance ☐Disability ☐Other *(Specify)* _____

IV. The Information to be disclosed from my health record: *(check appropriate box(es)*
☐Entire Record including medical records prepared at Care Physicians, P.A. and those medical records received at Care Physicians, P.A. from external healthcare providers, including but not limited to records related to laboratory services, Sleep Study services, _____
☐Only information related to (*specify)* _____
_____
☐Only the period of events from _____ to _____
☐ Other (*specify)(CHS,Billing, etc.)*_____

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:
☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health (*Other than Psychotherapy Notes)*
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the Custodian of Medical Records, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining Insurance coverage or a policy of Insurance, other law may provide the Insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated.

_____
(Specify new date)

I understand that Care Physicians, P.A. will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) Research related or (2) Provided solely for the purpose of creating Protected Health Information for disclosure to a third party. I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45-CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

_____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE (*State relationship to patient*) Date

_____
SIGNATURE OF WITNESS (*If signature of patient is a thumbprint or mark):* Date

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5USC 552a (i)(3)).

PATIENT IDENTIFICATION	NAME(*Last, First, Mi)*	RECORD NUMBER
	ADDRESS	
	CITY/STATE	DATE OF BIRTH