MEDICAL CLINIC OF HOUSTON L.L.P.
1701 Sunset Boulevard
Houston, Texas 77005-1713
(713) 526-5511
(713) 526-0451 (FAX)

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please print all information, then sign and date this authorization form at the bottom.

Patient Name _____ **DOB** _____ **MCH Account #** _____

Phone (Home) _____ **(Other)** _____

Type of Authorization: Authorization for release of protected health information via fax or voicemail and to the person(s) designated by patient.

Description of information to be disclosed: Please provide a clear description of the information that may be disclosed to the individual(s) identified below or on the fax number or voicemail number listed below and restrictions, if any.

☐ Appointment confirmation or reminder ☐ Billing information
☐ ECG/Non-invasive cardiology results ☐ Lab results ☐ X-Ray results
☐ Other - specify: _____
☐ Restrictions - specify: _____

☐ **NO RESTRICTIONS**, you can share any of my protected health information with the individual(s) identified below or on the fax or voicemail listed below.

Fax # _____ **Voicemail #** _____

Person or persons who may receive information _____

Right to revoke or terminate: As stated in the Clinic's Notice of Privacy Practices, I have the right to revoke or terminate this authorization. This can be done in person or by mailing a request to:

Medical Clinic of Houston, L.L.P.
1701 Sunset Blvd.
Houston, Texas 77005
Attn: Privacy Officer

Re-disclosure: I understand that it is my responsibility to notify Medical Clinic of Houston, L.L.P. (the "Clinic") of any change in my fax and voicemail numbers or change in persons authorized to receive information about me. I understand that the Clinic has no control over persons who may have access to the fax and voicemail numbers I have listed above. Therefore, I understand that my protected health information disclosed via either of those methods will no longer be protected by the requirements of HIPAA and will no longer be the responsibility of the Clinic.

By signing below, I am authorizing my physician and the Clinic to disclose and discuss my protected health information as directed above. I confirm that this authorization to release information is consistent with my wishes and is voluntary. This document supersedes all prior authorizations I have signed. I understand and agree that the Clinic will not be held liable for releasing my protected health information in accordance with an earlier authorization signed by me prior to any changes or restrictions made above.

_____ _____
Signature of Patient or Legal Representative **Date**

_____
Printed Name (if other than patient)

Relationship Parent/Conservator/Guardian/Other _____
If the patient is unable to sign this request, please provide a Medical Power of Attorney, or Declaration of Guardianship.