HOUSTON PULMONARY MEDICINE

11920 Astoria, Suite 320
Houston, Texas 77089
Phone: 281-484-9369 ~ Fax: 281-484-4210

Patient Name: _____

Date of Birth: _____ Social Security #: _____

Patient's Mailing Address: _____

_____

Telephone Number: Home: _____ Alternate: _____

Information to be disclosed:

☐ Dates of treatment _____

☐ Specific test results _____

☐ Entire medical record, dates _____

Information to be disclosed: ☐ to ☐ from

Organization: _____

Address: _____

_____

Phone Number: _____ Fax Number: _____

Purpose of disclosure: _____

I authorize the disclosure of health information as described above. I understand:

- This authorization is valid for 180 days unless otherwise stated here: _____.
- A photocopy or fax of this authorization is as valid as the original.
- I may revoke this authorization at any time by submitting a revocation in writing. If I revoke this authorization, the revocation will not apply to information already released in good faith before the revocation was received.
- Treatment may not be conditioned on my completion of this authorization form.
- If the recipient identified above is not covered by Federal or Texas privacy laws, the information may not be protected under these laws once it is disclosed to the recipient and may be subject to re-disclosure by the recipient.
- I may be asked to provide proof of my identification with this authorization.
- Fees/charges will comply with all laws and regulations applicable to release protected health information. Payment is due at the time of release of information.

_____ _____

Signature of Patient or Qualified Personal Representative Date

_____

Printed name of patient or qualified personal representative

Authorization for Disclosure of Health Information
Houston Pulmonary Medicine