

Release of Information

Patient Authorization for Use & Disclosure of Protected Health Information

By signing below, the patient or legal representative of the patient agrees to disclose individually identifiable health information pertaining to the care of

Name: _____ Address _____

City _____ State _____ Zip _____

Phone _____ Date of Birth ____ / ____ / ____

Specifically, this document authorizes **Karen Brooks MD PA**, officed at

4500 Williams Dr, Suite 212-369, Georgetown, TX 78633, (512) 637-2595, (512) 637-2599 FAX

to give and receive, use and/or disclose

session notes intake/assessment diagnosis and medications

with the individual or agency listed below

Name: _____ Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

The information will be used or disclosed for the following purpose(s)

continuing care legal personal records

The information will be

faxed mailed given verbally

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the typed address above.

This authorization will expire on (enter date or defined event) _____

Patient Name

Signature of Patient or Legal Representative

____ / ____ / 2010
Date

form revised 2010.06.02