ST. LUKE'S MEDICAL CLINIC

AUTHORIZATION FORM
For Release of Protected Health Information

By signing this form, I authorize you to use and disclose the protected health information described below.

Patient Name: _____DOB:_____

The health information you may release subject to this authorization is as follows:

- ☐ Complete Medical Records
- ☐ Consultation Reports
- ☐ Progress Notes

- ☐ Laboratory Tests
- ☐ Radiology Reports
- ☐ Physicians' Orders

- ☐ Prescriptions/Samples
- ☐ Speak To Over Phone
- ☐ ALL OF THE ABOVE

If **OTHER,** please specify:_____

Release my protected health information the following person(s)/entity:

Name:_____ Relationship to Patient: _____

Street:_____ City: _____State:____ Zip:_____ Phone #:_____

This authorization shall be in force and effective indefinitely unless specified below with a term date or term event:_____

☐ **I DO NOT GIVE PERMISSION FOR YOU TO RELEASE MY INFORMATION TO ANYONE.**

I understand that I have the right to revoke this authorization in writing at any time by sending a written notification to the following clinic address:

St. Luke's Medical Clinic
6363 San Felipe, #150
Houston, TX 77057
Phone # 713-972-8900
Fax # 888-876-4946

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPPA privacy regulations.

The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

_____   _____

Signature of Patient or Authorized Representative   Date

_____

Print Name of Patient or Authorized Representative