



**Patient Authorization for Use and Disclosure of Protected Health Information**

By signing, I authorize Texas Family Medicine to use and/or disclose certain protected health information (PHI) about me to:

**Name:** \_\_\_\_\_

**Street:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_

This authorization permits Texas Family Medicine to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

\_\_\_\_\_

The information will be used or disclosed for the following purpose:

\_\_\_\_\_

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will be in effect for an indefinite period until I revoke it in writing.

I do not have to sign this authorization in order to receive treatment from Texas Family Medicine. In fact, I have the right to refuse to sign this authorization. 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 privacy officer at:

Texas Family Medicine  
8380 Warren Pkwy, Ste 100  
Frisco, TX 75034

Signed by: \_\_\_\_\_  
Signature of Patient or Legal Guardian      Relationship to Patient

\_\_\_\_\_      \_\_\_\_\_  
Print Patient's Name      Date

\_\_\_\_\_

Print Name of Patient or Legal Guardian, if applicable