Uvalde Family Practice Assn.

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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:

Patients Name: _____ Date of Birth: _____

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

_____

Release my protected health information to the following entity:

Uvalde Family Practice Association
1800 Garner Field Road
Uvalde, Texas 78801
Fax Number: (830) 278-3427

The reason or purposes for this release of information are as follows:

_____

This authorization shall be in force and effective until the following event and/or date: _____

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

Uvalde Family Practice Association

I understand that the revocation is not effective to the extent that the practice has relied on this authorization in its action. 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 is 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 Personal Representative Date

_____ _____
Name of Patient or Personal Representative Description of Personal Representative's Authority