AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ DOB:_____

I authorize the release of my medical records:

From: _____

_____

_____

To: Quynh-Thu "Gigi" Doan, M.D.
777 South Fry Road, Suite 202
Katy, Texas 77450
281-717-4366 – phone
281-717-4367 – fax

I specifically authorize the use and disclosure of the following Protected Health Information to be released or exchanged, including (check all that apply):

_____History and physical
_____Discharge and Summary
_____Behavioral Health Treatment
_____Laboratory Reports
_____Medication Records
_____Treatment
_____Continuity of Care
_____Other (please specify):
_____

I understand that my health and behavioral health records are protected from disclosure under Federal and/or state law. I may revoke this authorization. This authorization is valid until I revoke it or 60 days after I have completed treatment, whichever is sooner. Once I revoke this authorization, no information can be released except as authorized or allowed by law. File copy is considered equivalent to the original.

This authorization was explained to me and I signed it of my own free will on:

_____
Date

_____
Signature of Patient

_____
Signature of Parent, Guardian, or Authorized Representative, if required