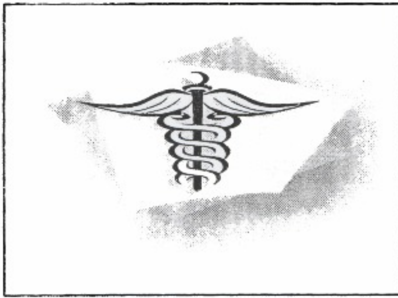

Uses for Disclosure of Protected Health Information

Federal law says that we cannot share your health information without your permission except in certain situations. If you sign this form, you are giving us permission to share your health information.

Print Name: ______________________________________

Social Security Number: ____________________________ DOB: ____________________

I give permission to **Park Lakes Family Medicine, P.A.** to share my health information with:

Name:	
Address:	
City/State/Zip:	
Phone:	

Park Lakes Family Medicine, P.A. may share my health information on the information listed below for the purpose of:

	Physician Referral		Legal
	Personal		Other
	Insurance		

Explain other:

I request that the following health information be shared:

	Entire medical record		Prescription history		Office reports/notes
	One year of history		Lab reports		Hospital records
	Three year history		Diagnostic films/reports		Accounting reports/ stmts
	Other:				

The following sensitive information must be specifically initialed to be included:

	HIV/AIDS related records		Mental health records/information
	HBV or TB related records		Domestic violence
	Other communicable disease		Drug or alcohol diagnosis/treatment*
	Genetic information/testing		

I understand that, if a person or entity that receives my personal health information is not a health care provider or health plan the information described above may be re-disclosed and no longer protected by the HIPAA Privacy regulations. However, the recipient is prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

The person I am authorizing to use and/or disclose the information may not receive compensation for doing so.

I also understand that I may refuse to sign this authorization and my refusal to sign will not affect my capacity to obtain treatment or payment of eligible benefits.

I understand that I may revoke this authorization in writing at any time except to the extent that has taken place up to the date of the revocation notice or unless a specific date is listed below: Authorize disclosures up to _____________ , 20________.

This form must be signed by EITHER the recipient OR by the personal representative. The recipient's parent may sign for the recipient if the recipient is a minor.

Signature of Patient:_______________________________________ Date:______________

If this form is signed by the personal representative, please include a copy of the document naming the personal representative, for example, a Power of Attorney, Personal Representative Designation form, or order appointing a guardian or executor.

Signature of Personal Representative:______________________________ Date:______________

Relationship to Patient:____

Park Lakes Family Medicine * 1305 W. Parkwood Ave. Friendswood, TX 77546 * (281) 996-0068 * Fx (281) 996-0186 * Online Form
This form and all of it's contents and design are solely owned by Park Lakes Family Medicine, P.A. The written contents on this form is confidential and not to be be seen and/or copied or used by any person(s) other than the appropriate Park Lakes Family Medicine staff members.

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