**Your Family Doktors**
201 Blossom Street
Suite B
Webster, TX 77598
281.332.3713
281.332.4654 Fax

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

**TO PHYSICIAN/FACILITY**

I hereby authorize the following physicians(s):

D**r. Kathy Hansen  Dr. Mark Hooker  Elizabeth Jones, PA**

To **receive** the protected health information **from:**

_____

_____

_____

_____

For the purpose(s) of**: Doctor's Release, Insurance, Continuity of Care, Other**

Information to be released should pertain to the patient:

**Name_____ DOB_____**

□ History & Physical  □ Radiological Studies

□ Laboratory  □ Progress Notes

□ Consultation  □ Other

This authorization shall be enforced and effective for one year from the date of signature.
I understand that I gave the right to revoke this authorization at any time by sending a written notification to the office of Your Family Doktors.
I understand that a revocation is not effective to the extent that the practice has relied on the authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or policy itself.
I understand that the information used or disclosed pursuant to this authorization may be subject to the redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations

_____ _____

Signature, Patient or authorized representative  Date