UTHealth | McGovern Medical School
The University of Texas Health Science Center at Houston

TSC
University of Texas – Memorial Hermann TSC Center of Excellence
TS Alliance Gold Standard Clinic

Authorization for Use and Disclosure of Protected Health Information

Patient Name:_____ Date of Birth:_____
Address:_____ Telephone:_____
_____ Email:_____

I hereby authorize_____
Facility Name

to release information from the medical records of _____
Patient Name

to: Hope Northrup, MD 6431 Fannin St. MSB 3.149 Houston, TX 77030
Name/Address of person/Organization to which disclosure is to be made

Telephone:_____ Fax: 713-383-1475

for treatment dates:_____
Specify dates

for the following purpose: [] Medical Care [] Patient Request []Other (specify below)

_____

Information to be used or disclosed:

[] Lab	[] H&P	[] Emergency Room	[] Cardiac Studies
[] Imaging/Radiology	[] MD Progress Notes	[] MD orders	[] Operative/Procedure Reports

[] Other:_____

This authorization is valid until the 180th day after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked, and covers only treatment(s) for the dates specified above.

I, the undersigned, have read the above and authorized the staff of (write in name of facility)_____ To disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above name facility and its parent company from all liability and damages resulting from the lawful release of my protected health information. I understand that I do not have to sign authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under "for the following purpose." I can inspect or copy the protected health information to be used or disclosed.

_____ _____
Signature of Patient/Parent/Conservator/Guardian Date Signed

_____ _____
Relationship to Patient/Authority to Sign Witness Signature