Capital ObGyn Associates of Texas, PA
12201 Renfert Way, Ste 325
Austin, TX 78758

Authorization Form for Release of Protected Health Information

By signing this form, I authorize *Capital OBGyn Associates of Texas* to disclose protected health information described below by telephone, fax or mail.

Patient Name: _____ DOB: _____

The information you may release subject to this authorization is as follows: (Example: appointment date/time, explanation of diagnosis and/or procedures, billing information, etc)

_____

_____

Release my protected health information to the following person(s)/entity:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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 person at the practice:

ATTN: Practice Manager
12201 Renfert Way, Suite 325
Austin, Texas 78758
Ph. (512)836-2536, Fax (512)284-8063

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. 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 used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my treatment, payment, and enrolment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

_____

Patient Signature Date

_____

Witness Signature Date