Medical Colleagues of Texas, LLP

21700 Kingsland Blvd., Suite 202
Katy, Texas 77450
281.398.8639 / 281.398.5019 (fax)

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____Date of birth_____

I authorize the following individual to disclose the above named individual's health information:

Name:_____

Address:_____City_____Zip_____

Phone #_____Fax #_____

This information may be disclosed to and used by the following individual and their practice:

____ Kelly McCullagh, M.D. ____ Tiffany Mullin, M.D. ____ Bethany Peterson, M.D. ____ Jane Ellis, WHNP

for the purpose of:_____

Please release the following:

____ **Most recent Pap Smear and/or Mammogram**

____ **All records between the dates of** _____ **and** _____

____ **Records pertaining to** _____

****IF REQUESTED RECORDS EXCEED 25 PAGES, PLEASE MAIL TO THE ABOVE ADDRESS ****

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
___**Yes**, I consent to the release of this information. ___ **No**, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date:_____.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness