Houston Pulmonary Sleep & Allergy Associates
21216 Northwest Freeway, Suite 430, Cypress, TX 77429
Phone: 281-955-0338 Fax: 281-469-0741

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

City, State, Zip: _____

I hereby authorize the use or disclosure of protected health information as described below.

RELEASE MY MEDICAL RECORDS TO:

☐ Houston Pulmonary Sleep & Allergy Associates
21216 Northwest Freeway, Suite 430, Cypress, TX 77429
Phone: 281-955-0338 Fax: 281-469-0741

☐ OTHER:
_____
_____
_____

RELEASE MY MEDICAL RECORDS FROM:

☐ Houston Pulmonary Sleep & Allergy Associates
21216 Northwest Freeway, Suite 430, Cypress, TX 77429
Phone: 281-955-0338 Fax: 281-469-0741

☐ OTHER:
_____
_____
_____

For treatment dates *(required)*: _____

Purpose of Disclosure *(required)*:

☐ Continued Care
☐ Attorney/Litigation
☐ Other *(please specify)*:_____
☐ Insurance
☐ Disability Services

Specific Information to be Sent *(required)*:

☐ Lab/Pathology
☐ Imaging/Radiology
☐ Emergency Room
☐ History & Physical
☐ Discharge Summary
☐ Operative/Procedure Report
☐ Consultations
☐ Pulmonary Studies
☐ Progress Notes
☐ Physician Orders
☐ All Pertinent Records
☐ Other*(please specify)*:_____
☐ Entire Record ***EXCLUDING*** - HIV Testing & Chemical Dependency
☐ Entire Record ***INCLUDING*** - HIV Testing & Chemical Dependency
☐ Entire Record ***INCLUDING*** - HIV Testing Only
☐ Entire Record ***INCLUDING*** - Chemical Dependency Only

This authorization is for one year after I, or my personal representative, signs this form. I have the right to revoke this authorization in writing at any time to the Privacy Officer, 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 named facility and its parent company from all liability and damaged resulting from the lawful release of my protected health information.

_____

Signature of Patient or Personal Representative **Date**

_____

Printed Name of Patient or Personal Representative

If you are a Personal Representative signing on behalf of the patient, please indicate your relation to the patient:

☐ Parent
☐ Legal Guardian
☐ Power of Attorney
☐ Executor or Personal Representative
☐ Other:_____