MEDICAL CLINIC OF BELLAIRE, P.A.
DR. ESTHER GUY

Patient Authorization for Disclosure of Protected Health Information
Please print all information, sign and date authorization form at the bottom.

Patient Name: _____ Date of Birth: _____

Designated Person: I authorize Medical Clinic of Bellaire, P.A. to disclose or provide protected health information about me, to (identify person or persons who will receive the Information):

_____

_____

_____

Description of information to be disclosed: I authorize Medical Clinic of Bellaire, P.A. to disclose the following protected health information about me to the person or persons identified above (please provide a written description of the information to be disclosed):

_____

_____

_____

Expirations or termination of authorization: I understand that I have the right to terminate this authorization at any time. I must notify the Privacy Office in writing, Should I decide to terminate the authorization.

Right to revoke or terminate: As stated in our Notice of Privacy Practices, I have the right to revoke or terminate this authorization by submitting a written request to our Privacy Office. This can be done in person or by mailing a request to:

Medical Clinic of Bellaire, P.A.
5959 West Loop South Suite 510
Bellaire, TX 77401

Redisclosure: We have no control over the person or persons you have listed to receive your protected health information. Therefore, your protected health information disclosure under this authorization will no longer be protected by the requirements of the Privacy rule and no longer be the responsibility of our clinic once released.

_____ _____
Patient Name (please print) Date

_____
Patient Signature