NORTH HOUSTON ORTHOPEDICS AND SPORTS MEDICINE

AUTHORIZATION TO RELEASE INFORMATION

Last name:	First Name:
DOB:	Social Security #:

☐I hereby authorize the use or disclosure of protected health information for the purpose of:

☐Continuity of Care ☐Insurance Request

☐Treatment ☐At the request of the patient

☐Legal Investigation/Action ☐Other_____

To:	Address/City/State:
Phone:	Fax:

Information to be disclosed (unless indicated only one year treatment notes will be sent):

☐Entire Medical Record ☐Billing Records

☐Radiology film or images ☐Progress/Treatment Notes

☐Surgery Records ☐Other: _____

AUTHORIZATION FOR THE RELEASE OF INFORMATION

☐I hereby authorize the use or disclosure of protected health information for the purpose of continuity of care and treatment to:

☐E. Shawn Mansour, D.O. or ☐David, Navid, D.O

North Houston Orthopedics and Sports Medicine
P.O. Box 6969 The Woodlands, TX 77380
Fax: 281. 970.5118

Information to be disclosed:

☐Entire Medical Record ☐Billing Records

☐Radiology film or images ☐Progress/Treatment Notes

☐Surgery Records ☐Other:_____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I am giving authorization to use, disclose, or exchange my health information. I understand that I may be charged a fee for record copies. I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the privacy officer in writing. I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I understand that the information used or disclosed may be subject to re-disclosure by the person or facility receiving it and may not be protected by federal privacy regulations. I understand that this authorization will not expire unless I submit in writing to the privacy officer.

Signature:	Date:
Witness/Title:	Date: