Prime Healthcare Providers, PLLC

Dr. Phillip Weinstein (General Practice) ~ Dr. Adam Weinstein (Internal Medicine)
902 Frostwood, Suite 262 ~ Houston, Tx 77024
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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____ Social Security #:_____

I HEREBY AUTHORIZE THE FOLLOWING PHYSICIAN OR ORGANIZATION -

FROM

Practice/Doctor's Name:_____ **Phone:**_____ **Fax:**_____

Street Address:_____ **City/State:** _____ **Zip:**_____

TO DISCLOSE MY HEALTH INFORMATION FROM MY MEDICAL RECORDS TO:

TO

Practice/Doctor's Name: Prime Healthcare Providers PLLC / Dr. Phillip Weinstein / Dr. Adam Weinstein

Street Address: 902 Frostwood, Suite 262, **City/State:** Houston/ Texas **Zip:** 77024

Include the following items:

- ❑ All Records
- ❑ EKG Reports
- ❑ Consultations
- ❑ Genetic Testing Information
- ❑ History/Physical Exams
- ❑ Immunizations
- ❑ List of Allergies
- ❑ Laboratory results
- ❑ Medication Lists
- ❑ Progress Notes
- ❑ X-Ray/Imaging reports
- ❑ Exclude (Specify) _____

I understand that the information in my health records 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. I understand that the information released is for the specific purpose of caring for my health and any other use of this information without the written consent of the patient is prohibited.

I understand that I have the 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 this 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 will expire on the following date, event or condition: _____. If I fail to specify and expiration date, event or condition, this authorization will expire in six months.

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 federal HIPAA Privacy Rules may not protect the information. If I have questions about disclosure of my health information, I may contact Angela Gomez / privacy officer for Prime Healthcare Providers PLLC / Phillip Weinstein, M.D., P.A. at the following address: 902 Frostwood, Ste 262, Houston, TX 77024.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Witness Date

COMPLETE ONLY IF INFORMATION IS RELEASED DIRECTLY TO THE PATIENT

I understand that my medical records may contain reports; test results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries, I will not hold Prime Healthcare Providers, PLLC or my physician individually liable for any misinterpretation of the information in my medical records as a result of not consulting my physician for the correct information.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If legal representative) Witness