

Dr. Peter Bigler, Staci Pavelka, FNP, & Brittany Besong, PA-C  
6769 Lake Woodlands Dr. Suite E  
The Woodlands, TX 77382  
P: (281) 210-1200 F: (281) 210-1210

### AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

*This authorization may be used to permit a covered entity to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.*

**Patients**  
Name: \_\_\_\_\_  
Other Names Used: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**Records being released FROM:**  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

**Records being released TO:**  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

**Information to be disclosed**

- Medical Records for the previous 2 years
- Hospital/Emergency Room Records
- Other: \_\_\_\_\_

**Include: (Initial)**

\_\_\_\_ Drug, Alcohol, or Substance Abuse Records

\_\_\_\_ Mental Health Records

\_\_\_\_ HIV/Aids Related Information

**Reason for Release:**

- Treatment/Continuation of Care
- Personal Use
- Billing/Insurance Purposes
- Other (specify): \_\_\_\_\_

**The individual signing this form agrees and acknowledges as follows:**

- **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.
- **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made.
- **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
- **Special Information:** This authorization may include disclosure of information relating to DRUG, ALCOHOL, SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION, except psychotherapy notes, CONFIDENTIAL HIV/AIDS RELATED INFORMATION, and GENETIC INFORMATION only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.
- **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

**SIGNATURES**

Patient/Legal Representative: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

If Legal Representative, relationship to Patient: \_\_\_\_\_

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol, or substance abuse, and mental health treatment.

Signature of Minor: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_