AGAPE Physicians
6769 Lake Woodlands Drive Suite E The Woodlands, Tx 77382
P: (281) 210-1200 F: (281) 210-1210

Authorization to use or disclose protected Health Information

This authorization is 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 sections that apply to their decisions relating the use or disclosure of their protected health information.

Patients Name: _____

Other Names Used: _____ DOB: _____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____

Records being released FROM:

Name:_____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____
Fax: (_____)_____

Records being released TO:

- Dr. Peter Bigler
- Dr. Erika Brito-Goodson
- Dr. Jerissa Belsha
- Staci Pavelka, FNP-BC
- Brittany Besong, PA-C
- Demetria Burges, PA-C

(NO Disk Please)
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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: _____

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The individual signing this form agrees and acknowledges the following:

Voluntary Authorization: This authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits (as applicable) will not be conditioned upon my singing of the 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 may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws

SIGNATURES

Patient/Legal Representative/Parent: _____ 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 disease, and drug, alcohol, or substance abuse, and mental health treatment.