

Authorization to Release Protected Health Information (PHI)



1. Patient Demographic Information

- Full Name: _____
- Date of Birth: ____ / ____ / ____
- Phone Number: _____
- Email (optional): _____
- Address: _____

2. Clinic Information (Entity Releasing the Information)

Clinic Name: MASON PARK MEDICAL CLINIC
Address: 21770 KINGSLAND BLVD KATY, TX 77450
Phone: 281.646.0740
Fax: 281.646.0743

3. Recipient of Records (Who May Receive the Information)

I authorize the release of my medical records to:

- Name/Facility: _____
- Address: _____
- Phone: _____
- Fax: _____
- Email (if applicable): _____

4. Purpose of Release

- Continuing medical care
- Legal purposes
- Insurance
- Personal use
- Other: _____

5. Patient Authorization and Signature

I understand that:

- I have the right to inspect or copy the health information to be used or disclosed.
- I may refuse to sign this authorization, and treatment will not be conditioned on signing.
- Information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations.

Signature of Patient or Legal Representative: _____

Printed Name: _____

Relationship to Patient (if not self): _____

Date: ____ / ____ / ____

Information to be Disclosed

Records to be released (check all that apply):

- All medical records
- Office visit notes
- Labs / Diagnostics
- Imaging / Radiology reports
- Immunization records
- Mental health records (requires specific consent)
- Other (please specify):

Date(s) of service to be released:

From ____ / ____ / ____

To ____ / ____ / ____

- All dates of service