HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Print Name of Patient: ____________________________________Date of Birth: _______________

I. My Authorization

I authorize the following using or disclosing party:

____

to use or disclose the following health information:

☐ - All of my records

☐ - Other: ____

The above party may disclose this health information to the following recipient:

Name and organization: ***The Gill Center for Plastic Surgery & Dermatology***
Drs. Paul and Anita Gill
9200 Pinecroft Dr., Ste 460 & 465, The Woodlands, TX 77380
281-853-5308 (office) 281-377-0946 (fax)

The purpose of this authorization is (check all that apply):

☐ - At my request

☐ - Other: ____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Printed Name: _______________________Signature of Patient: _____________________Date:_________