

## Authorization for Use and Disclosure of Health Information

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The type and amount of information to be used or disclosed is as follows: *(include dates where appropriate)*
  - \_\_\_ All Health Care information, including Lab, X-Ray
  - \_\_\_ All Health Care information including information relating to HIV/AIDS testing, sexually transmitted diseases, disorders / mental health or drug and/or alcohol use.

**OR**

- \_\_\_ All Health Care Information excluding information relating to HIV/Aids testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use.
- \_\_\_ Others: \_\_\_\_\_

3. I understand that the information in my health record 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.
4. This information may be disclosed **to** and **used by** the following individual or organization as my personal representative, to act on my behalf:

**DFW Internal Medicine Clinic PLLC**

Petua Okolo, DO, RPh.  
601 Omega Drive, Suite 204  
Arlington TX 76014-2075  
817-465-7400

Records are being requested for the following purpose(s): \_\_\_\_\_

5. Please **circle** your response to the following:
  - a. May we leave messages concerning appointments with a co-worker, receptionist or secretary who regularly answer your calls? **Yes No N/A (circle one)**
  - b. May we leave messages on a voice mail at your home? **Yes No N/A (circle one)**
  - c. May we leave messages on a voice mail at work? **Yes No N/A (circle one)**
  - d. May we discuss appointments/treatment with spouse/parent/guardian/family? **Yes No N/A (circle one)**

List Names: \_\_\_\_\_

6. I understand that I have a right to revoke this authorization at any time. I understand that I need to inform the office, in writing, of any changes in your directives. I understand that this HIPPA notice will be kept in my file. 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 \_\_\_\_\_ .
7. 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 assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.
8. **Fees:** I understand that copies are subject to a minimum charge of \$25.00 and prepayment is required before records are copied. Make all checks payable to DFW Internal Medicine Clinic; and mail payment to: Attn: Billing Department, DFW Internal Medicine Clinic, 601 Omega Drive, Ste 204, Arlington TX 76014.

\_\_\_\_\_  
**Signature of Patient or Legal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
Description of Legal Representative's Authority (ATTACH NECESSARY DOCUMENTS)