Katy Medical &Wellness
Methodist West Houston, MOB 1
18400 Katy Freeway, Suite 590
Houston, Texas 77094
(281) 492-1900
www.mykatymedical.com

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____

Patient's Phone Number:_____

I hereby authorize Katy Medical & Wellness, assigns and heirs to use and disclose my individually identifiable Protected Health Information (PHI) in the manner described below. I understand that my PHI may be re-disclosed by the person or entity receiving my PHI from Katy Medical & Wellness assigns and heirs, and that it then may no longer be protected by federal privacy regulation. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.

This authorization covers the following PHI:

Category of PHI

Medical Records	Claims/Billing information	Mental Health Records
Drug / Alcohol Abuse	HIV & Hepatitis Test Results	Genetic Test Results

Amount of PHI Authorized (please check and answer option 1 or 2):

1. Entire PHI (all categories noted above unless otherwise specified by patient below)_____
2. Please limit use and disclosure of my PHI to:_____

-----[Examples- "Laboratory results from July 1998"; "Mental health record from January 2001 to present"]

The recipient (s) of my PHI is: Katy Medical & Wellness, assigns and heirs.

I authorize my PHI to be used and disclosed at my request for all medical purposes.

This authorization will expire: **AT THE PATIENTS'S VERBAL OR WRITTEN REQUEST**

I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying Katy Medical & Wellness, assigns and heirs in writing. I understand that my revocation or modification of this authorization will not affect any action taken by Katy Medical & Wellness, assigns and heirs, in reliance of this authorization before Katy Medical & Wellness, assigns and heirs, receives my request for revocation or modification. I must sign my written request and send it to:

Katy Medical &Wellness
Methodist West Houston MOB1
18400 Katy Freeway, Suite 590
Houston, Texas 77094
(281) 492-1900

Signature:_____

Date:_____