AUTHORIZATION TO USE OR DISCLOSE
PROTECTED HEALTH INFORMATION

Information regarding patient for whom authorization is made:
Full Name: _____ ("Patient")
Other Name(s) Used: _____ Date of Birth_____
Address: _____City: _____State: ____ Zip Code: _____
Phone: (_____) _____ Email (*Optional*): _____

Health care provider or health care entity authorized to disclose this information:

Flora Medical Clinic, PLLC 3921 Steck Ave., Ste. A110, Austin, Texas 78759

Information regarding person or entity who can receive and use this information:
Name: _____
Address: _____City: _____State: ___ Zip Code: _____
Phone: (_____) _____ Fax: (_____) _____

If all health information is to be released, then initial only the first line below. If certain information is to be withheld, please place your initials on the applicable lines below:

_____**Patient's Entire Medical Record,** including histories; office notes; test results, including HIV/AIDS-Related information and test results; drug, alcohol, or substance abuse records; radiology studies; films; referrals; consults; billing records; mental health records, insurance records; and records received from other health care providers.

Exclude: (*Indicate by Initialing*)
_____ Drug, Alcohol or Substance Abuse Records
_____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)
_____ Genetic Information (Including Genetic Test Results)
_____ Mental Health Records (Flora Medical Clinic does not possess any psychotherapy notes of Patient.)

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; or permission is withdrawn; or the following specific date (optional): _____ (Month) _____ (Day) _____ (Year).

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to Flora Medical Clinic. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

RECORDS FEE REQUIREMENTS *PRIOR TO* RELEASE. I understand Flora Medical Clinic will disclose the requested medical records indicated herein to the physician/entity named within fifteen (15) days from receipt of this authorization. I understand that if I request my records to be faxed to my new provider, there is no charge. If I request my medical records to be copied to paper or on a CD, however, I will be provided with an invoice to pay the fee associated with this request, which shall be no more than twenty-five dollars ($25.00) for the first twenty pages, and fifty cents (.50) for each page thereafter for medical records in paper format. I understand that I am required to pay this invoice and that Flora Medical Clinic is not required to comply with this request until and unless I pay the fees associated with this authorization.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures 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 or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

_____ _____

Signature of Patient or Patient's Legally Authorized Representative **Date**