



HIPAA Authorization for Release of Information Form

I hereby authorize use or disclosure of protected health information about me as described below.

RECORDS ON (PATIENT NAME) _____ (DOB) _____

The following specific person or class of persons or facility is authorized to make the requested use or disclosure:

RECORDS MAILED FROM: _____

The following person or class of persons may receive disclosure of protected health information about me.

RECORDS MAILED TO: _____

Specific description of information to be released (must include date(s) of service):

The information to be released will be used for the purpose described below:

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke or withdraw this authorization by notifying **SADLER CLINIC** in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

This authorization will expire on _____, or 1 (one) year after the date of said authorization.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

Signature of Individual Date of Signature Date of Birth or SS Number

-- OR, if applicable --

Signature of Guardian Date of Signature Description of Guardian's
Personal Representative's
Authority to Act for the
Individual

A copy of this completed, signed and dated form must be given to the Individual or person signing on the Individual's behalf. The form should be mailed to: Sadler Clinic, Attention: Medical Records, 508 Medical Center Blvd., Conroe, TX 77304.