Omar M Jeroudi, MD PA
17490 Highway 3, Suite A300
Webster, TX 77598
Ph: 281-724-9940 Fax: 832-632-1979

Authorization for Use and Disclosure of Protected Health Information

To comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) 1996 and state law, OMAR M JEROUDI, MD PA is requesting your authorization for use and release of health information.

PATIENT INFORMATION:

Name_____ Medical Record#_____ Date of Birth__/__/____
Last, First, Middle

I authorize OMAR M JEROUDI, MD PA to
□ Release to □ Obtain from the following individual or organization:

Name/Entity: _____ Ph: _____ Fax: _____

Address:_____

Purpose of Disclosure:

_____

Type of Request:

□ **Entire Record, or**
□ History & Physical □ Consultations □ Discharge Summaries □ Laboratory Reports □ Radiology / Imaging
□ Pathology reports □ Other; please specify_____

INITIAL _____ □ I DO □ I DO NOT consent to release of information relating to psychiatric or psychological testing or treatment, alcohol and/or drug abuse diagnosis, prognosis and treatment and/or HIV (AIDS) testing and/or results, or such disclosure shall be limited to the following specific types of information:

_____

Note: If this section is not completed, records of this type if they exist for this patient will not be released.

Expiration Date:

This authorization expires (180) days from the date of my signature or on___/____/ _____
mm dd yyyy

Authorizing person:

_____ _____
Print Name Relationship to Patient

_____ _____
Signature Date

Patient, spouse, legal representative, or beneficiary (patient's spouse may authorize disclosure of the patient's health information only when the health information is for the sole purpose of processing an application for health insurance, for enrollment in a health care service plan or an employee benefit plan, and where the patient is to be an enrolled spouse or dependent under the policy or plan)

I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by those regulations.

_____ _____ _____
Signature Print Name Date

You are not required to sign this form as part of treatment or payment
****You may refuse to sign this authorization****

Patient or other party signing this authorization form has the right to receive a copy of the authorization form. Any information being released is for the specific purpose stated above and any other use of this information without the written consent of the patient is prohibited. The authorization may be changed or revoked, in writing, to prevent disclosure of information, except for any previous use of protected health information made in good faith under this authorization. OMAR M JEROUDI, MD PA and its staff are hereby released from any legal responsibility or liability for disclosure of the above information covered under this authorization.