Women's Health
TEXAS

Release of Protected Health Information

Patient Name: ____ **DOB:** ___________

I grant permission for my healthcare provider and their representatives of WHTX to discuss my care, as it becomes relevant, using this disclosure form to share information about my healthcare or discuss financial information for payment on my account with family or friends.

Are there any specific people you would like the staff at WHTX to disclose medical/appointment information to?

WE WILL NOT TALK TO ANYONE THAT IS NOT ON THIS FORM, INCLUDING YOUR SPOUSE, PARENT OR CHILDREN.

Release my protected health information to the following person(s)/entity:

Name: ______________________________ Phone:__________________ Relationship: ________________

Name: ______________________________ Phone:__________________ Relationship: ________________

Name: ______________________________ Phone:__________________ Relationship: ________________

The information you may release subject to this authorization is the following:

Appointment date/time: ☐ **Yes** ☐ **No** Explanation of diagnosis and/or procedures: ☐ **Yes** ☐ **No**

Lab reports: ☐ **Yes** ☐ **No** Billing information: ☐ **Yes** ☐ **No**

____ _________________________

Patient / Guardian Signature Date

------------------------------OR------------------------------

☐ **I <u>do not</u> want any of my information shared with family or friends**

____ _________________________

Patient Signature **Date**

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that to revoke this consent, I must provide written notice to Women's Health Texas.