Noor J. Ferrell, D.O., PLLC
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Sugar Land, TX 77478
(281)-410-8356

Authorization to Use/Disclose Health Care Information

Patient Name: _____ **Birth date**: _____

Maiden or other name (if applicable)_____

I request and authorize _____ to release the healthcare information described below to:

Name: _____

Address: _____

City, State: _____ **Zip code**: _____

Method of delivery (if fax, specify number): _____

This request and authorization applies to only the following protected health information:

____ HISTORY / PHYSICAL EXAM _____ LABORATORY REPORTS _____ CONSULTATIONS
____DISCHARGE SUMMARY _____ DOCTOR'S ORDERS _____ PROGRESS NOTES
____PSYCHIATRIC REPORTS / TESTS _____ PSYCHOLOGICAL REPORTS _____BILLING RECORDS
____INITIAL PSYCHIATRIC EVALUATION _____ OTHER _____

During the following time period or dates: _____

Purpose(s) of this use/disclosure: _____

Authorization expires: _____ (date or event)

Each disclosure made with the patient's written consent must be accompanied by the following written statement:

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R.Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. [52 FR 21809, June 9, 1987; 52 FR 41997, Nov. 2, 1987]

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to Noor J. Ferrell, D.O.

I understand that information disclosed based on this authorization may be subject to re-disclosure by the recipient, and no longer protected by federal privacy regulations.

Signature: _____ Date: _____