AUTHORIZATION FORM

Rheumatology Clinic of Houston, P.A. ("Covered Entity") is requesting _____ or his or her representative ("Patient"), to authorize the use and/or disclosure of certain Protected Health Information (as defined in 45 CFR 164.501) to _____.
The Protected Health Information for which authorization is requested can be specifically described as all information concerning my medical care or treatment plan that is contained within my medical chart. Authorization for the use and/or disclosure such Protected Health Information is requested for purposes of sharing of information.

CONDITIONS:

- The Patient agrees that the Covered Entity may disclose the Patient's Protected Health Information to the above named individual/organization only for the purposes listed above.

- Once the information above is released, the information may be subject to re-disclosure by the recipient and will not be protected under the privacy rules promulgated under the Health Insurance Portability and Accountability Act of 1996.

- The Covered Entity will provide the Patient with a copy of the Protected Health Information for which this authorization is being sought upon the written request of the Patient.

- The Covered Entity may not condition treatment, payment, enrollment, or eligibility for benefits (as applicable) on whether the Patient signs this authorization.

- The Patient is voluntarily signing this authorization.

- The Patient will receive a copy of the signed authorization.

- This authorization is in effect until ***December 31, 2023.*** After that time, this authorization is automatically revoked and no further use or disclosure of the Patient's Protected Health Information is permitted to the above-stated person or entity beyond that date.

- The Patient has the right to revoke this authorization at any time. This revocation must be in writing, and submitted to the following address:

  Rheumatology Clinic of Houston, PA
  Attn: Paula Brett, HIPAA Officer
  11307 FM 1960 West, Suite 240
  Houston, Texas 77065

- Once this authorization is revoked, the Covered Entity will not use or disclose the Protected Health Information for the above-stated purpose except to the extent that the Covered Entity has already relied on the authorization.

SIGNATURES:

Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____

Witness: _____ Date:_____