Karan S. Bhalla, MD, Amita S. Bhalla, MD
Andres F. Vasquez, MD, Angela B. Shiue, MD
5413 Crenshaw Rd, Suite 400 Pasadena, TX 77505
Phone (713) 943-2800 Fax (713) 943-2801

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please complete all highlighted sections.

Section 1. I,_____(print name) authorize the following health care provider and/or organization to disclose the following protected health information to the designated person and/or organization for the purpose(s) listed below:

Section 2. Information disclosed by: Orion Medical (name of health care provider/organization) 5413 Crenshaw Blvd, Suite 400, Pasadena, TX 77505 (address) 713-943-2801 (fax number) 713-943-2800 (phone number)	***Section 3.*** Information to be received by: _____ (name of person or organization) _____ (address) _____ (fax number) _____ (phone number)
Section 4. The information to be disclosed: ☐ Medical record ☐ Billing record ☐ Other (please specify) _____ _____ _____ _____ _____	***Section 5.*** The information is to be: ☐ Mailed ☐ eMailed _____ ☐ Picked up by _____ ☐ Faxed to _____ ☐ Phoned to _____ ☐ Other(please specify) _____ _____

Section 6. The information is disclosed for the following use(s): _____
This authorization shall expire (date or event): _____

Section 7.

☐ ***I do, or*** ☐ ***do not*** consent to the disclosure of information pertaining to psychiatric or psychological evaluation or treatment.

☐ ***I do, or*** ☐ ***do not*** consent to the disclosure of reportable communicable diseases including sexually transmitted diseases and HIV(AIDS) evaluation or treatment.

☐ ***I do, or*** ☐ ***do not*** consent to the disclosure of substance/alcohol abuse evaluation or treatment.

Section 8. By signing below, I understand the following:

1. I may revoke the authorization at any time by sending a written revocation to the health care provider/organization designated above.
2. Any treatment, payment, or my enrollment in any health plan or eligibility for benefits will not be affected if I do not sign this *authorization*.
3. Any information disclosed my this authorization to any person/organization not a health care provider, business associate of a health are provider or health plan covered by federal and state privacy regulations could be re disclosed by the recipient and no longer protected by those regulations.
4. I am entitled to receive a copy of this signed authorization.

Section 9.

_____ (signature of patient) _____ (date of birth) _____ (date signed)

_____ (address) _____ (phone number)

(signature of personal representative if not signed by patient) _____