TIMARRON FAMILY MEDICINE, PA
200 PECAN CREEK DRIVE
SOUTHLAKE, TX 76092
817.481.4739 PH 817.481.5198 FAX

Patient name: _____ Date of Birth _____

Previous name: _____

I. <u>My Authorization</u>

You may use or disclose the following health care information (check all that apply):

□ All my health information maintained by the above-named practice

□ My health information relating to the following treatment or condition: _____

□ My health information for the date(s):_____

□ Other:_____

You may disclose this health information to:

Name (or title) and organization_____

Address: _____City _____State _____Zip_____

Phone: _____ Fax: _____

Reason(s) for this authorization (check all that apply):

□ At my request
□ Other (specify)_____
_____
_____

This authorization ends: □ On (date) _____
□ When the following event occurs
_____

II. <u>My Rights</u>

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study.

  or

- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from the office.

  or

- Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)