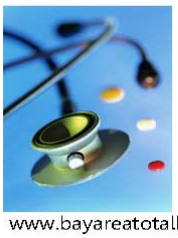

Bay Area Total Health Medical Group, PA

www.bayareatotalhealth.com

Houston Physicians Hospital
333 N. Texas Avenue, Suite 4100
Webster, TX 77598
832.984.6549 Phone
281.338.7755 Fax

Authorization for Release of Medical Information

Name of physician to which disclosure is to be made:
Pamela Dugano-Daphnis, M.D.

Authorization for Medical Information

Release ☐	**Request ☐**	**Inspection ☐**
Amendment of Protected Health Information ☐		

Patient Name:			
Date of Birth:	**Social Security #**		**Medical Record #:**
Address:			
City:	**State:**	**Zip:**	**Phone #:**

I hereby authorize: _____

Name of Physician/Facility

_____

Complete Address of Physician/Facility

Phone # _____ *Fax#* _____

to release information from the medical record of: _____

For treatment dates: **FROM:** _____ **TO:** _____

*Specify Dates – This Line **Must Be** Completed*

to ***Bay Area Total Health Medical Group, PA, - Pamela Dugano-Daphnis, M.D.*** at the address as listed above on this form for the following purpose:

☐ Medical Care ☐ Legal ☐ Insurance ☐ Other (*Detail Reason Below*)

_____

SELECT PORTIONS OF MEDICAL INFORMATION TO BE RELEASED:

☐ Office Visit Progress Notes		☐ Registraton Summary	☐ Entire Record, ***Including*** HIV Testing Only
☐ Immunizations	☐ MD Orders	☐ Entire Record	☐ Entire Record, ***Including*** Chemical Dependency Only
☐ EKG	☐ Lab	☐ Entire Record ***Excluding*** HIV & Chemical Dependency	☐ Entire Record ***Including*** HIV & Chemical Dependency
☐ Imaging	☐ Radiology	☐ Other:	

This authorization is valid until the 180th day after the date it is signed unless it provides otherwise, not to exceed 24 months or unless it is revoked and covers only treatment(s) for the dates specified above.

_____ (Initials) *I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS immunization.*

I, the undersigned, have read the above and authorize the above authorized staff to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above name facility all liability and damages resulting from the lawful release of my Protected Health Information.

_____ _____ _____

Date *Signature of Patient/Parent/Conservator/Guardian* *Authority/Relationship to Patient*

Fees/Charges will comply with all laws and regulations applicable to the release of Protected Health Information.
Payment is due at time of release.