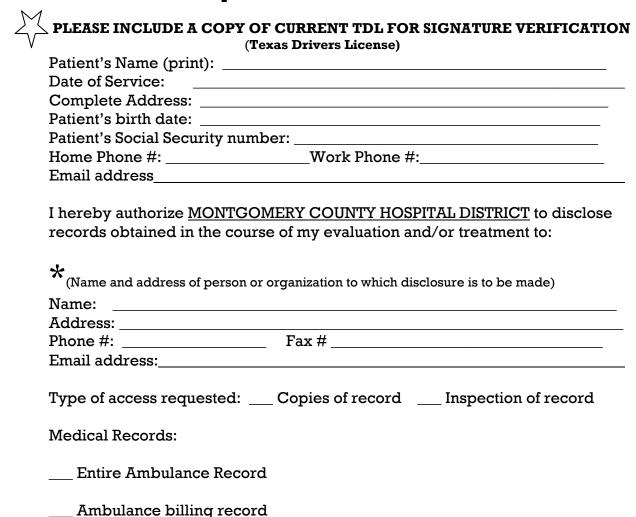


MONTGOMERY COUNTY HOSPITAL DISTRICT P.O. BOX 478

CONROE, TX. 77304 (936)-523-1110 FAX (936) 539-1163

Authorization to Use and Disclose Specific Protected Health Information



I understand that I have the right to revoke this Authorization at any time except to the extent that action has already been taken and if not earlier revoked. To revoke this Authorization, I understand that I must contact the privacy officer at the medical provider's location.

I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer subject to privacy protections provided by law.

I understand that I have the right to inspect and copy the information that is to be used or disclosed as part of this Authorization.

A copy or facsimile of this authorization is as valid as the original.

authorize the disclosure of the protection of th	cted health information as stated. PLEASE INCLUDE A COPY OF CURRENT TDL FOR SIGNATURE VERIFICATION
	Date
(Signature of patient or legal representative)
*If signed by other than patient, indic	cate relationship and submit authority:
This authorization expires 180 days fr	rom the date of signature:

I acknowledge that I have read the provisions in this Authorization and that I have the right to refuse to sign this Authorization. I understand and agree to its terms and

*Authorized representative must submit copies of legal document supporting his or her authority to act on the patient's behalf.