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

PLEASE INCLUDE A COPY OF CURRENT TDL FOR SIGNATURE VERIFICATION
(Texas Drivers License)

Patient's Name (print): _____
Date of Service: _____
Complete Address: _____
Patient's birth date: _____
Patient's Social Security number: _____
Home Phone #: _____Work Phone #:_____
Email address_____

I hereby authorize MONTGOMERY COUNTY HOSPITAL DISTRICT to disclose records obtained in the course of my evaluation and/or treatment to:

*(Name and address of person or organization to which disclosure is to be made)
Name: _____
Address: _____
Phone #: _____ Fax # _____
Email address:_____

Type of access requested: ___ Copies of record ___ Inspection of record

Medical Records:

___ Entire Ambulance Record

___ Ambulance billing record

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.

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 authorize the disclosure of the protected health information as stated.

PLEASE INCLUDE A COPY OF CURRENT TDL FOR SIGNATURE VERIFICATION

_____
Print name

_____ Date_____
(Signature of patient or legal representative)

*If signed by other than patient, indicate relationship and submit authority:

_____

_____

This authorization expires 180 days from the date of signature:
_____ (expiration date).

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