Patient Authorization for Use & Disclosure of Protected Health Information, Release of Information

I, __________________________ hereby authorize ____

(Print your name) (Name of Healthcare Provider)

At ____ (_____)__________-_____________

(Healthcare Facility/Name of Provider and Phone Number)

to use and/or disclose certain Protected Health Information (PHI) listed below to the office of Dr. Brynna Connor

FAX: 8 8 8 – 9 7 9 – 9 2 1 0

SPECIFIC RECORDS TO BE SENT: ____

The information will be used or disclosed for the purpose of continuity of care. The purpose is provided so that I can make an informed decision whether to allow release of the information. This authorization will expire one year from the date signed.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. I do not have to sign this authorization in order to receive treatment from Brynna Connor, M.D. I have the right to refuse to sign this authorization. When my 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 by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

My written revocation of this consent must be submitted to the privacy officer at Brynna Connor, M.D.

Phone 512-382-9500 || Brynna Connor, M.D. || 2906 Medical Arts Street, Austin, Texas 78705

Patient Name: Date of Birth:

Phone Number:

Signature: _____________________ Date:_________________