



# GEORGETOWN MEDICAL CLINIC

3201 S AUSTIN AVE STE 210 ★ GEORGETOWN TEXAS 78626

## PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize **Georgetown Medical Clinic** to **use** and/or **disclose** certain **protected health information (PHI)** about me to or for the party or parties listed below.

This authorization permits **Georgetown Medical Clinic** to **use** or **disclose** to \_\_\_\_\_ the following individually identifiable **health information** (Person or Entity to Receive the information describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.). \_\_\_\_\_

\_\_\_\_\_

This authorization will expire on \_\_\_\_\_.  
{Expiration Date or Defined Event}.

When my information is **used** or **disclosed** pursuant to this authorization, it may be subject to redisclosure 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 **Georgetown Medical Clinic** has acted in reliance upon this authorization. My written revocation must be submitted to **Georgetown Medical Clinic's** Privacy Officer **Georgetown Medical Clinic**.

Signed by: \_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian