Katy Rheumatology
& Associates, P.A.

AUTHORIZATION TO RELEASE INFORMATION

"I HEREBY AUTHORIZE THIS PRACTICE TO MAKE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO PROVIDE, COORDINATE, OR MANAGE MY HEALTH CARE AND ANY RELATED SERVICES. THIS INCLUDES THE COORDINATION OR MANAGEMENT OF MY HEALTH CARE WITH A THIRD PARTY. (INFORMATION ABOUT ME IN MY MEDICAL RECORDS AND/OR FINANCIAL RECORDS) AS INDICATED BELOW."THIS INFORMATION IS TO BE DISCLOSED TO:

KATY RHEUMATOLOGY ASSOCIATES
PADMA CHIMATA, M.D.
19770 KINGSLAND BLVD. #305
KATY, TEXAS 77094
281-578-7438 FAX: 281-578-7450

PATIENT NAME:_____

PATIENT ADDRESS:_____

DATE OF BIRTH_____

DESCRIPTION OF INFORMATION TO BE DISCLOSED_____

REASON FOR REQUESTED USE OR DISCLOSURE_____

TO BE READ AND SIGNED BY PATIENT

I UNDERSTAND THE FOLLOWING:

A. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY PROVIDING WRITTEN NOTICE TO THIS PRACTICE.
B. I MAY NOT BE ABLE TO REVOKE THIS AUTHORIZATION IF THE PRACTICE HAS ALREDY TAKEN ACTION UTILIZING THIS AUTHORIZATION OR IF THE AUTHORIZATION WAS OBTAINED AS A CONDITION OF OBTAINING INSURANCE COVERGE.
C. THE PRACTICE WILL NOT CONDITION TREATMENT OR PAYMENT BASED ON MY SIGNING THIS AUTHORIZATION.
D. I AM SIGNING THIS AUTHORIZATION FREELY.
E. NO ON HAS PRESSURED ME TO SIGN THIS AUTHORIZATION.
F. THE INFORMATION DISCLOSED IN THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE PRACTICE AND NO LONGER PROTECTED UNDER FEDERAL LAW.
G. I ACKNOWLEDGE THAT I HAVE HAD AN OPPORTUNITY TO REVIEW THIS AUTHORIZATION AND UNDERSTAND THE INTENT AND THE USE.
H. IF REQUESTED, I WILL RECEIVE A COPY OF THIS AUTHORIZATION.

PATIENT SIGNATURE_____DATE_____

SIGNATURE OF PATIENT REPRESENTATIVE_____DATE_____

UNLESS REVOKED IN WRITING THIS AUTHORIZATION WILL REMAIN IN EFFECT INDEFINATELY