# AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Dr. Heidi B. Doucet P.L.L.C.
3732 N. 16th Street Orange, TX 77632
(409) 883-4821 (409) 883-9311 fax
Heidi Doucet, Privacy Official

Patient Name ________________________________________

Patient Address ________________________________________

Patient Phone Number ________________________________________

I authorize Dr. Heidi B. Doucet P.L.L.C. to release health information identifying me (including, if applicable, information about substance abuse, mental health conditions, and HIV infection or AIDS) under the following conditions:

☐ Exam records ☐ Billing records
☐ Glasses prescription ☐ Contact lens prescription
☐ Other (describe specifically)___________________________
_________________________________________________

The purpose of the release: at the request of the individual / or other:___________________
These records are for services provided on the following date(s):________________________

Please send(or discuss) the records listed above to (use additional sheets if necessary):

| | |
|---|---|
| Name: _________________________ | Name: __________________________ |
| Address: _______________________ | Address: ________________________ |
| _________________________ | ___________________________ |
| Phone: _________________________ | Phone ___________________________ |
| Fax: _________________________ | Fax: ___________________________ |

This authorization shall expire no later than: ___/___/___ or upon the following event
________________________(whichever is sooner), and may not be valid for greater than two years from the date of signature for medical records from this facility.

It is completely your decision whether or not to sign this authorization form. We will not refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you may revoke it at any time by contacting in writing, FAX or email the Privacy Official noted in the *Notice of Privacy Practices*.

When your health information is disclosed under this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

__________________________________________ ___________________
Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

_______________________________________ ___________________________
Representative Relationship to Patient