Authorization to Use or Disclose Protected Health Information

Lifetime Family Health Center PLLC

2637 Ira E Woods Ave Suite 300, TX 76051 (817)310-0301 F (817) 423-6701

As required by the Privacy Regulations, Lifetime Family Health Center may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without authorization.

I hereby authorize: Clinic Name or Doctor _____

Phone Number _____ Fax _____

To disclose: Health Records to Lifetime Family Health Center PLLC

2637 Ira E Woods Ave Suite 300, Grapevine, TX 76051 (817)310-0301 F (817) 423-6701

Patient Name_____ Date of Birth_____

Address_____

Patient Health Information to be disclosed:

_____

Effective dates for this authorization:_____ (This authorization will expire in 90 days)

I Understand I have a right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous confidence on the uses or disclosure pursuant to this authorization.
2. Knowledge of any renumeration involved due to any marketing as allowed by this and as a result of this authorization.
3. Refuse to sign this authorization
4. Restrict what is disclosed in this authorization

I also understand that if I do not sign this document, it will not condition my treatment, payment enrollment in a health plan, or eligibility for benefits whether or not I provided authorization to use or disclose protected patient health information.

Patient Signature/Guardian_____ Date_____