MEMORIAL AND KATY SURGICAL SPECIALISTS
Authorization for the Disclosure of Protected Health Information

Patient name:_____ Date of birth:_____

Address:_____ Telephone #:_____

City, State, ZIP:_____

I hereby authorize the release of medical records

FROM:	**TO:**
_____	_____
Name	Name
_____	_____
Address	Address
_____	_____
City, State, ZIP	City, State, ZIP
_____	_____
Fax #	Fax #

Information to be released:

_____Complete copy of medical record
_____Consultation report
_____Diagnostic tests
_____Other:_____
_____History and physical
_____Operative report
_____Lab

I understand that the medical information may include, but is not limited to communicable disease such as the Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AID's), drug, alcohol, substance abuse of psychiatric disorder.

Purpose of disclosure:_____

I understand that this authorization may be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this executed authorization. I understand that I may revoke this authorization at any time by submitting a written request to the office of Memorial and Katy Surgical Specialists.

This authorization expires one year from the date signed or upon the specified event:_____

I understand that the potential exists for information disclosed pursuant to this authorization to be subject to re-disclosure and is no longer protected by HIPAA. Memorial and Katy Surgical Specialists, its employees, officers or attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

_____	_____
Patient/Guardian Signature	Date signed
_____	_____
Witness	Date signed