**HELEN M. SCHILLING, M.D.**

Physical Medicine and Rehabilitation

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T: 281. 586. 0542

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**Authorization for Release of Protected Health Information**

I authorize **Dr. Helen M. Schilling** to \_\_\_\_\_ release to: \_\_\_\_\_ release from:

Person or Organization Address

Phone # Fax #

Information/copies from the medical records on:

Patient Date of Birth SS#

Date(s) of Service

**INFORMATION TO BE RELEASED:**

\_\_\_\_\_ All Medical Records \_\_\_\_\_ 1st and Last Office Visits

\_\_\_\_\_ Radiology Reports \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This information is being released for the following purposes:

\_\_\_\_\_ Continued Care \_\_\_\_\_ Insurance \_\_\_\_\_ Other

I understand I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that in any event, this authorization shall expire (180) days from the date of signature, unless specified in writing here:

Name Date

I understand if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

**TO THE PARTY RECEIVING THIS INFORMATION:** This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains.

**FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2**

Signature of Patient or Legally Authorized Representative Date

Relationship to Patient

Print Name of Legally Authorized Representative

Witness-Printed Name Date

Witness - Signature