Mark D. Le M.D., P.A.
Medical Clinic

602B Lawrence Street Tomball, TX 77375
Tel: (281) 255-6333 Fax: (281) 255-6335

846 11th Street Hempstead, TX 77445
Tel: (979) 921-0647 Fax: (979) 921-0245

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ SSN: _____

City / State / Zip: _____ Tel: _____

Information to be Release FROM:	Information to be Released TO:
❒ Mark D. Le M.D.,P.A. ❒ _____ Organization _____ Address City State ZIP _____ Phone Fax	❒ Mark D. Le M.D.,P.A. ❒ _____ Organization _____ Address City State ZIP _____ Phone Fax

❒ Mail Records ❒ Pick Up Records ❒ Fax Records to: _____

Information to be Released

Dates of service for records requested FROM: _____ TO: _____ ❒ All Dates of Treatment

❒ All Records
❒ Clinic notes
❒ Laboratory tests
❒ Radiology reports
❒ Pathology reports
❒ EKG / Cardiovascular
❒ Pulmonary Function Tests
❒ Bills
❒ Others: _____

Purpose of Release

❒ Continuing Care ❒ Copies for own use ❒ Transfer to another provider ❒ Legal
❒ Coordination with School ❒ Other _____

Authorization for General Release of Information

This authorization shall be effective for 90 days following date of signature unless an earlier date is specified:

_____/_____/_____

Sensitive Records may require specific patient authorization. Please check the applicable box below to request the following records:

❒ Mental Health Treatment ❒ Sexually Transmitted Diseases ❒ AIDS/HIV Treatment ❒ Alcohol/Drug Abuse Treatment

I understand that by signing this authorization:

- I authorize the use of disclosure of my individual identifiable health information as described above for the purpose listed. I understand that this authorization is voluntary.
- I understand the Notice of Privacy Practices provides instructions should I choose to revoke my authorization.
- I understand if the organization I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I understand I have the right to receive a copy of this authorization.
- I understand that I am signing this authorization voluntarily and that treatment, payment, or eligibility for my benefits will not be affected if I do not sign this authorization.

Signature of Patient/Legal Representative

_____ _____ _____
Signature Date Relationship to the Patient