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

PERMISSION TO SHARE LIMITED HEALTH INFORMATION

PATIENT INFORMATION					
Patient's last name:	First:		Middle:	❑ Jr. ❑ Sr.	Social Security no.:
Account No.:	DOB: / /	Sex: ❑ M ❑ F	Home phone no.: ( )		Cell no.: ( )

Patient Acknowledgement:

I give permission to the person(s) listed in the table below to receive limited health information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family and/or friend in order to assist with continuing care. Any information that does not pertain to assisting with my health care and any copies of medical records will require a signed HIPAA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

Date of Permission	Name of Individual & Relationship to Patient	DOB	Comments/Instructions (i.e. may pick up meds, may disclose test results)	Patient / Guardian Initials

The physician and staff has my permission to: (Please check all that applies)

❒ Leave message at home with my spouse or: Name: _____

Relationship: _____ DOB: _____

❒ Leave message on my cell phone. Cell phone number: _____

❒ Leave message at work. Work phone number: _____

❒ Leave message on voicemail. Phone number: _____

❒ Leave a detailed message on answering machine. Phone number: _____

Signature of Patient/Legal Representative		
_____	_____	_____
Signature	Date	Relationship to the Patient