

HIPAA RELEASE
Authorization to Disclose Protected Health Information

I, _____, Principal, authorize, with this HIPAA Release - Authorization to Disclose Protected Health Information ("Authorization"), any covered entity or health care provider to disclose all of my protected health information, including mental health records (excluding psychotherapy notes); drug, alcohol, or substance abuse records; genetic information (including genetic test results); and HIV/AIDS test results/treatment, at the request of any of the following Authorized Recipients:

Falco & Falco, Attorneys at Law
1903 Dove Crossing Lane, Suite C
Navasota, Texas 77868
936-825-6533

This Authorization is effective immediately and has no expiration date. It shall expire only in the event I revoke this Authorization in writing and is not affected by my subsequent disability or incapacity.

This Authorization may be revoked at any time by giving written notice stating my intent to revoke to the covered entity or health care provider. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, or any other method evidencing receipt by the Authorized Recipients. I understand that prior actions taken in reliance on this Authorization by the Authorized Recipients, who had permission to access my health information, will not be affected. There are no exceptions to my right to revoke this Authorization.

My refusal to sign this form will not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1).

I understand that I cannot be denied treatment based on a failure to sign this Authorization, and that a refusal to sign will not affect the payment, enrollment, or eligibility for any benefits.

I further understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

_____, Principal
(Print name)

SUBSCRIBED AND SWORN TO BEFORE ME by the said _____,
Principal this _____ day of _____, 20__.

Notary Public, State of Texas