

**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED
HEALTH INFORMATION UNDER HIPAA**

I authorize my physician or office staff to use or disclose the following protected health information (PHI) to other physicians or therapeutic providers, hospitals, billing, claims or insurance companies:

All dates of service, types of service, all levels of detail from any and all sources.
OR
 Only the following PHI: _____

This PHI is being used or disclosed for the following purposes:
Check one:

Transfer of care to another doctor
 Continuing treatment, payment or health care operations at: _____
 At the request of the patient
 Only the following purposes: _____

This authorization remains in effect until (specify one):

Date or Event: _____
Written cancellation notice is received: _____
No expiration: _____

FROM: _____ TO: _____

The Texas State Board of Medical Examiners approves an initial fee of \$25 for the first 25 pages of a record and \$.50/page thereafter. To simplify this formula, CFP will charge \$25 for the first 25 pages, \$35.00 for 21-100 pgs. or \$50 for 100 pgs. or more. These amounts are less than those allowed by the TSBME. These fees apply if copies are requested by you, an attorney, insurance carrier, a new doctor or third party on your behalf. Fifteen days should be allowed for our office to provide records after a signed authorization and payment is received.

I understand that I have the right to review CFP's Notice of Privacy Practices located at 912 Cap. of Tx. Hwy., Austin Texas, 78746. I understand that I have the right to revoke this authorization, in writing, by sending such written notice to the CFP Privacy Contact at the address above. I understand that a revocation is not effective to the extent that my doctor has relied on the use or disclosure of PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that the PHI used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient

Print name and D.O.B.

Date

Parent or Personal Representative

I understand this information will be provided within 30 days from receipt of a request and a fee for preparing and furnishing this information may be charged.

_____ The fee is waived if the records are used to support an application for disability or benefits under: AFDC, Medicaid, Medicare, SSI or Federal Old Age Survivors Insurance. I have attached a statement which confirms that an application or appeal has been filed or is pending.