

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

NAME OF PATIENT OR INDIVIDUAL:

Last		First		Midd	Middle	
DATE OF BIRTH: N	/lonth	Day	Year			
ADDRESS:						
CITY:			STATE:	ZIP):	
			ALT. PHONE: (
EMAIL ADDRESS:						
I AUTHORIZE TH	E FOLLOWING	TO DISCLOSE 1	HE INDIVIDUAL'S PR	ROTECTED HEALTH	I INFORMATION	
Organization Nam	ne: Houston Ar	ea Pediatric Ne	urology			
_	24514 King	sland Blvd				
	Katy, TX 77	494				
	WHO CAN	N RECEIVE AND	USE THE HEALTH IN	FORMATION?		
Person/Organizat	ion Name:					
Address:						
			State:			
Phone: ()			Fax: ()			
	w	/HAT INFORMA	TION CAN BE DISCLO	OSED?		
	information					
o Progress/0	Consultation N	otes				
Progress/0Lab Result	Consultation No	otes				
Progress/0Lab ResultDiagnostic	Consultation No ts Test Reports	otes				
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