Family Medicine

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name **Date of Birth**

I,_____, hereby authorize the use and/or disclosure of protected health information (PHI) to
(Self/Parent/ Guardian)

To: Tehmina Sami M.D. P.A.
13440 University Blvd Suite 180
Sugar Land, TX 77479

Telephone: 281-994-7911
Fax: 281-994-7921

From: _____
_____

Dates of Service _____ to _____

I understand that the information in my record may include information relating to sexually transmitted diseases which may include, but are not limited to diseases such as hepatitis, syphilis, gonorrhea, the human immunodeficiency virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS). It may also include information about behavior or mental health services and treatment for alcohol and drug abuse.

I understand that I can revoke or terminate this authorization by submitting a written revocation to the address listed below except to the extent that disclosure made in good faith has already occurred in reliance on this consent. If I have questions about this disclosure, I can contact Tehmina Sami M.D. P.A. at 281-994-7911.
If neither federal nor Texas privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Texas privacy law.

_____ _____
Signature of Patient or Legal Representative **Printed Name**

_____ _____
Relationship to Patient(If Legal Representative) **Date**

TEHMINA SAMI M.D. P.A. 13440 University Blvd, Suite 180. SUGAR LAND, TX 77479
PH: 281-994-7911 **Fax 281-994-7921**
Tehmina Sami, M.D P.A.

_____
Staff Witness Signature **Date Requested**