Authorization to Release Protected Health Information
To Fort Bend Premier Care

Ivan N. Mefford MD PhD*Anthony Lundquist MSN, APRN, AGPCNP-BC**
Rosalinda Morales, PhD, RN, FNP-BC*Mohsin Qadri, MD**

1. I, _____, hereby authorize:
   Physician's Name: _____
   Address: _____
   Telephone/Fax: _____
   to release my protected health information to Fort Bend Premier Care, 1505 Liberty St, Richmond, Texas 77469, Telephone (281) 342-9500, FAX (281)342-6667.
   **********NOTE: PLEASE MAIL ALL RECORDS OVER 20 PAGES.** **********

   Release protected health information from the medical record of:

   Patient Name: _____
   Birth Date: _____

   Copies of the following records shall be used and disclosed:
   ____ Last Year; Last_____years of l Records; or
   ____ Other: _____ (specifically identify)
   _____

2. I understand that the records used and disclosed pursuant to this authorization form may include information relating to: Human Immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS"); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

3. I understand that copies of the records indicated above will be: (check all that are applicable)
   ___ Used by members of the Fort Bend Premier Care's workforce.
   ___ Sent/Faxed to: _____
   ___ Other _____

4. I understand that to the extent any Recipient of this information, as identified above, is not a "covered entity" under Federal or Texas privacy law, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the Recipient and, therefore, may be subject to re-disclosure by the Recipient.

5. I understand that the purpose(s) of the requested use and disclosure is (are):
   ____ At the request of the individual.
   ____ Other: _____
   _____

6. I understand that I may revoke this authorization in writing at any time except to the extent that Fort Bend Premier Care has already relied on this authorization. I understand that I may revoke this authorization by sending or faxing a written notice to *Privacy Officer, Fort Bend Premier Care 1505 Liberty S., Richmond, Texas 77469; and/or(281) 342-6667 fax* stating my intent to revoke this authorization.

7. Unless otherwise revoked, I understand that the specific date or event upon which this authorization expires is: _____.

8. I understand that the Fort Bend Premier Care may not condition treatment on my completion of this authorization form. . *[Or, if the covered entity is permitted to condition services on the individual's completion of the authorization form under 45 C.F.R. § 164.508(b)(4), this statement should explain the consequences to the individual of a refusal to sign the authorization (e.g., Fort Bend Premier Care's Group Health Plan may deny you enrollment or eligibility for benefits if you fail to complete this authorization form)].*

Signature of Patient/Patient's Legal Representative:_____ Date: _____
Printed Name of Legal Representative (if any):_____
Representative's Authority to Act for Patient: _____