Authorization for the Use and Disclosure of Protected Health Information
FROM Dr. Ivan N. Mefford MD PhD PA**dba Fort Bend Premier Care
Ivan N. Mefford MD PhD**Rosalinda Morales, PhD, RN, FNP-BC
Mohsin Qadri, MD**Anthony Lundquist MSN, APRN, AGPCNP-BC

1. I hereby authorize Dr. Ivan N. Mefford MD PhD PA to use and disclose protected health information from the record(s) of:

   Patient's Name: _____

   Birth date: _____

   Social Security No.: _____

2. Copies of the following records shall be used and disclosed:
   ____ Last year; Last_____years of Medical Records; or
   ____ Other: _____ (specifically identify)
   _____

3. 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.

4. I request that copies of the records indicated above be **Released To**:

   Name of Recipient: _____

   Name of Company: _____

   Address: _____

   City: _____ State: _____ Zip Code: _____

   Fax Number: _____ Telephone Number: _____

5. 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.

6. I understand that the purpose(s) of the requested use and disclosure is (are):

   ____ At the request of the individual.
   ____ Other: _____
   _____

7. I understand that I may revoke this authorization in writing at any time except to the extent that Dr. Ivan N. Mefford MD PhD, PA has already relied on this authorization. I understand that I may revoke this authorization by sending or faxing a written notice to *Privacy Officer, Dr.Ivan N. Mefford MD PhD PA; 1505 Liberty St., Richmond, Texas 77469; and/or (281) 342-6667 fax* stating my intent to revoke this authorization.

8. Unless otherwise revoked, I understand that the specific date or event upon which this authorization expires is: _____. *[The statement "end of the research study," "none," or similar language is sufficient if the authorization is for a use or disclosure of protected health information for research, including for the creation and maintenance of a research database or research repository.]*

9. I understand that Dr. Ivan N. Mefford MD Ph.D. PA 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., Ivan N. Mefford MD PhD PA's Health Plan may deny you enrollment or eligibility for benefits if you fail to complete this authorization form)].*

Signature of Patient or Patient's Legal Representative: _____ Date: _____

Printed Name of Legal Representative (if any): _____

Representative's Authority to Act for Patient: _____