PROVIDENCE FAMILY PRACTICE, P.A
9798 Bellaire Blvd. Suite D Houston, Tx. 77036
PHONE: 713-270-7224 | FAX: 866-831-7562

_____ _____ _____
Patient Name Date of Birth SS#

Address:_____ _____
Telephone #

I hereby authorize: **PROVIDENCE FAMILY PRACTICE** to release all of the following requested medical records

To: _____

Phone:_____ Fax:_____

For treatments dates:_____

For the following purposes: Medical Care- Legal- Insurance- Other

This authorization is valid until the 180th day after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked, and covers only treatment(s) for the dates specified above.

I, the undersigned, have read the above and authorize the staff of above named facility To disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extend the action has been taken in reliance upon it. I understand that when this information is used or disclose pursuant to this authorization, it may be subjected to re-disclosed by the recipient and may be longer be protected. I hereby released and hold harmless the above named facility from all liability and damages resulting from the lawful release of my *Protected Health Information.*

_____ _____ _____
Date Signature Relationship