AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize the following to use and/or disclose certain protected health information (PHI) about me:

Release records to: ________________________________ Obtain records from: ________________________________
________________________________ ________________________________
________________________________ ________________________________

If records are being released from Dr. Ron Byrd or Dr. Frances Killebrew, please select below:

________ Print records (see below for charges) ______ Mail records
________ CD - $25 only ______ Pick up records

This authorization permits disclosure of the following individually identifiable health information about me:

_____Complete Medical Record
_____Lab reports (excluding HIV reports), X-Ray reports
_____HIV lab reports
_____Specific information or specific dates (specify)____

The information will be used or disclosed for the following purpose:

_____At the request of the individual (to be used only if the patient is requesting the information for themselves)
_____Continuing medical care
_____Legal purposes
_____Other (specify)____

This authorization will expire on (enter date or defined event):

_____6 months from the date signed
_____Specific date (enter date to expire) _____________________
_____When revoked in writing
_____Other (specify)____

The Texas State Board of Medical Examiners approves an initial fee of $25.00 for the first 20 pages of a record and $.50 per page thereafter. These fees apply if you, an attorney, insurance carrier, a new doctor or third party on your behalf request copies. Fifteen business days should be allowed for our office to provide these records after a signed authorization and payment has been received.

This fee is waived if the records are used to support an application for disability or benefits under: AFDC, Medicare, Medicaid, Social Security Administration or Federal Old Age Survivors Insurance. I have attached a statement which confirms that an application or appeal has been filed or is pending.

I do not have to sign this authorization in order to receive treatment from Ron Byrd MD or Frances Killebrew M.D. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: Ron Byrd, M.D. 2765 Bee Caves Road Suite 201, Austin, TX 78746.

Signed: ________________________________ ________________________________ ___________________
Signature of Patient or Legal Guardian Relationship to patient Date

________________________________ ________________________________
Print Patient's Name Print Name of Legal Guardian, if applicable

____
Patient's Date of Birth

Parent/guardian must be provided with a signed copy of this authorization form if requested