PATIENT 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:

_____ C. Ron Byrd M.D. P.A.
2765 Bee Caves Road #201
Austin TX 78746
512-328-2752
512-328-2751 (fax)

Other Facility: _____
_____
_____
Phone: _____
Fax: _____

The information will be released to:

Other facility:_____
_____
_____
Phone:_____
Fax:_____

_____C. Ron Byrd M.D. P.A.
2765 Bee Caves Road #201
Austin, TX 78746
512-328-2752
512-328-2751 (fax)

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
_____Emergency room 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)_____

I do not have to sign this authorization in order to receive treatment from C. Ron Byrd, M.D., P.A. 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: C. Ron Byrd, M.D. P.A. 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