Park Lakes Family Medicine, P.A.

Aesthetics, Wound Care & Hyperbaric Medicine

Authorization for the Receipt of Protected Health Information

Print Name: ____

Social Security Number:_______________________________ DOB:________________________

I give permission to **Park Lakes Family Medicine, P.A** to receive my health information from:

____

____

____

Park Lakes Family Medicine, P.A. has authorization to receive my health information until this date of ____________________, or until I revoke the authorization in writing.

I request that the following health information be released:

- ☐ All of my health care information
- ☐ Information regarding prescription drug coverage
- ☐ Information regarding treatment for drug or alcohol abuse
- ☐ Information regarding behavioral health services or psychiatric care
- ☐ Information regarding Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)
- ☐ Other:____

This form must be signed by EITHER the recipient OR by the personal representative. The recipient's parent may sign for the recipient if the recipient is a minor.

Signature of Patient:____ Date:_________________

If this form is signed by the personal representative, please include a copy of the document naming the personal representative, for example, a Power of Attorney, Personal Representative Designation form, or order appointing a guardian or executor.

Signature of Personal Representative:________________________________ Date:_________________

Relationship to Patient:____

Park Lakes Family Medicine * 1305 W. Parkwood Ave. Friendswood, TX 77546 * (281) 996-0068 * Fx (281) 996-0186 * Online Form

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