Dr. Kiran Farheen
23920 Katy Freeway Suite 440
Katy, Texas 77494
Phone: 346-257-4299 * Fax: 832-802-0732

AUTHORIZATION FORM FOR RELEASE AND/ OR REQUEST OF PROTECTED HEALTH INFORMATION

Name_____ Date of Birth_____ Last 4 of Social Sec. No. _____

I hereby authorize Dr. Kiran Farheen to ☐ **Release /** ☐ **Request** my personal health record to use, disclose, and receive the protected health information described below for the following purpose(s):

☐ **Healthcare Management** ☐ **Healthcare Business and Regulatory Matters**
☐ **Continuation of Ongoing Care** ☐ **Transfer of Care** ☐ **Other:**_____

From: _____ Phone Number: _____ Fax Number: _____

To: _____ Phone Number: _____ Fax Number: _____

The health information **to be used and/or disclosed or received** is specifically described as follows:

☐ All my medical information ☐ Lab Results ☐ Imaging ☐ Progress Notes ☐ History and Physical

☐ Other:_____

I wish to **SPECIFICALLY WITHHOLD RELEASE** of information relating to the following:_____

_____

Dr. Kiran Farheen is hereby authorized to make the disclosure to or be in receipt of your healthcare information from the above classes of persons or entities, and the aforementioned classes of persons and entities are hereby authorized to use the disclosed information.

OPTIONAL: This authorization shall be in force and effective **UNTIL** the following event and/or date: _____
(OPTIONAL TO COMPLETE)

I understand that the specific information to be released may include but is not limited to management of drug or alcohol abuse, mental/psychiatric illness or communicable disease.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the following address:

Dr. Kiran Farheen
Attn: Privacy Official
23920 Katy Freeway Suite 440 - Katy, Texas 77494

I understand that a revocation is not effective retroactively such that such revocation would not apply to actions of the practice prior to its imposition. Also, a revocation is not effective if this authorization was provided as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed or received under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations. In accordance with Texas Administrative Code (TAC) Chapter 165, Dr. Kiran Farheen will charge an administrative fee of $25 for the first twenty pages and $.50 per page for every copy thereafter.

The practice will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure or receipt of my personal healthcare information.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed Name of Signer or Personal Representative Relationship to Patient