AUTHORIZATION TO RELEASE HEALTH INFORMATION

To: _____

Phone: _____

FAX: _____

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____

Date of Birth _____/_____/_____

This information may be **RELEASED TO** and used by the following individual or organization:

Karen L. Woods, MD _____

6560 Fannin Suite 2000 _____

Houston, TX 77030 **OR** _____

Phone: 713-383-7800 _____

FAX: 713-383-7888 (if records to be sent **from** Dr. Woods)

For the purpose of: ___ Ongoing Medical Care or _____

Please release the following:

___ Colonoscopy/EGD and pathology _____

_____ _____

_____ _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

___**Yes**, I consent to the release of this information.

___ **No**, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Karen L. Woods, MD.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Relationship to Patient (If Legal Representative) Witness