Kriste Babbitt, MD, PLLC
4550 Post Oak Place, Suite 320
Houston, TX 77027
(713) 622-5480

Authorization to Disclose/Obtain Protected Health Information

Patient Name: _____ **Birth date**: _____

Maiden or other name (if applicable)_____

I hereby authorize **Kriste Babbitt, MD** to **disclose / obtain** the following information **to /from**:

Name: _____

Address: _____

City/State/Zip: _____

Tel: _____ **Fax**: _____

Method of Delivery: _____

The reason for this disclosure is _____. My medical records may include information regarding diagnosis and treatment of **drug, alcohol, Acquired Immune Deficiency Syndrome (AIDS), HIV serology, or psychiatric disorders.** I understand that such information is confidential and is protected by federal law. Those receiving this information will be advised that federal regulations (42 CFR part 2) prohibit their making any further disclosure without my written consent or as otherwise permitted by such regulations. By **initialing** the spaces below, I specifically authorize the release or disclosure of the following protected health information and/or records, if such information and/or records exist:

___ HISTORY/PHYSICAL EXAM	___ LABORATORY REPORTS	___ CONSULTATIONS
___ DISCHARGE SUMMARY	___ DOCTOR'S ORDERS	___ PROGRESS NOTES
___ PSYCHIATRIC REPORTS/TESTS	___ PSYCHOLOGICAL REPORTS	___ IMAGING STUDIES
___ INITIAL PSYCHIATRIC EVALUATION	___ ALL/ANY	___ OTHER_____

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.

All consents to release the medical record will **expire on termination of treatment** unless otherwise indicated by the patient. I wish to have this consent expire on _____.

I understand that, unless action has already been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to Kriste Babbitt, MD.

I understand that information disclosed based on this authorization may be subject to redisclosure by the recipient, and no longer protected by federal privacy regulations.

Signature (patient or authorized representative): _____

Date _____ Relationship (if authorized rep.) _____