Rachel Winer, PhD
4130 Bellaire Blvd. , Suite 210
Houston, TX 77025

Authorization for Disclosure of Health Information

Physician's name:_____ _____
Address:_____
City:_____State:_____Zip:_____
Phone number:_____ Fax number:_____

Patient name:_____
Date of Birth:_____Phone:_____
Address:_____
City:_____State:_____Zip:_____
Phone number:_____ Fax number:_____

1. I authorize the use or disclosure of my health information to be released to:
Rachel Winer, PhD
4130 Bellaire Blvd. , Suite 210
Houston, TX 77025

2. The type and amount of information to be used or disclosed is as follows (include dates where appropriate).

_____Complete health records _____Lab results/X-ray reports
_____Physical exam _____Consultation reports
_____Other (please specify):_____

3. 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.

4. 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 Dr. Winer. 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. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____.

If I fail to specify an expiration date, event or condition, this authorization will expire in sixty (60) days. 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 assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that my disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of patient or legal representative Signature of witness

_____ _____
Date Date