AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Patient Name:______________________________Date of Birth:______________________________

I authorize the following organization to release information as stated below from the patient health information record:

Information to be released *FROM:*

(Primary care doctor or other significant provider of health/medical services)

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Information to be released *TO:*

Tangible Difference Learning Center
7010 NW 100 Drive, Suite A104
Houston, TX 77092
Ph. (713) 462-6060 Fax:(713) 462-6066
Email: director@tangibledifference.com
www.tangibledifference.com

Information to be Released

Dates of service for records requested:

Beginning ______________________________ **Thru** ______________________________

Other:
____

Purpose of Release: circle one

Continuing care copies for own use Transfer to another provider

Other:____

Authorization for General Release of Information

I understand that:

- Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time by writing to the Health Information Services Department. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.
- This authorization will expire 90-days from the date signed below unless another date or event is entered here: __________________

(Note: If the disclosure is to an employer or financial institution, this authorization will expire 90 days from the date signed by you.)

Signature of Patient/Legal Representative

________________	____________________________________	________________________
Date	Signature of Patient/Legal Representative	Relationship to the Patient