

VICTOR D. VELA, M.D., P.A.
PATIENT AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize VICTOR D. VELA, M.D., P.A. to use and/or disclose certain protected health information (PHI) about me to _____.

Name of entity to receive information

This authorization permits VICTOR D. VELA, M.D., P.A. to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.):

The information will be used or disclosed for the following purpose:

If requested by the patient, purpose may be listed as "at the request of the individual."

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____

{Expiration Date or Defined Event}.

The Practice will ___ will not ___ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from VICTOR D. VELA, M.D., P.A.. In fact, I have the right to refuse to sign this authorization.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: 24165 IH-10 West, #114, San Antonio, Texas 78257.

Signed by:

Signature of Patient or Legal Guardian

Relationship to Patient

Patient's Name

DOB

Print Name of Patient or Legal Guardian

Date

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION