



General and Laparoscopic Surgery

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Date: _____

I authorize **Northwest Houston Surgical** to Release to: Release from:

Person or Organization _____ Address _____

Telephone Number _____ Fax Number (If Applicable) _____

Information/copies from the medical records on:

Patient _____ Date of Birth _____ Social Security _____

INFORMATION TO BE RELEASED:

- Operative Report Lab Work Pathology Report Billing Records
- X-ray Reports Ultrasound CT Scans HIDA Scans
- ALL Other: _____

This information is being released for the following purpose:

- Continued Care Attorney/Litigation Insurance Disability Services
- Other: _____

PLEASE FAX OR MAIL RECORDS TO THE FOLLOWING ENCLOSURE:

**NORTHWEST HOUSTON SURGICAL ASSOCIATES
1631 N LOOP WEST, STE# 220
HOUSTON, TEXAS 77008
TELEPHONE: 713-426-2400
Fax: 713-426-3204**

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization shall expire (180) days from the date of my signature, unless specified in writing here:

_____.

I understand that if the recipient authorized to receive the information is not a covered entity, (i.e. insurance company or non-health care provider); the released information may no longer be protected by federal and state privacy regulations.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose.

FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2

Signature of Patient or Legally Authorized Representative _____ Date _____

Relationship to Patient _____

Print Name of Legally Authorized Representative _____ Date _____

Witness – Printed Name/Signature _____