CONROE ADHD SOLUTIONS

2040 N Loop 336 West, Suite 202, Conroe, TX 77304

(936) 524-4733 phone
(936) 463-6518 FAX
www.conroe-adhd.com

HIPPA Authorization for Release of Information

I authorize Conroe ADHD Solutions to release and disclose the protected health information for :

Name of Patient _____ DOB _____

to: ~~Name of Practice~~/Authorized agent (parents) _____

Address: _____

Fax _____ E-mail (parent e-mail)

Phone _____ Sent by [ ] Fax [✓] Email [ ] Manual

Specific description of information to be released:

___✓___ Clinic visit notes for dates: _____

This protected health information is being used or disclosed for the following purposes:

Transfer of care ___All___ Other information _____

_____

This authorization will expire on _____, or one year after the date signed below. If the person or entity receiving this information is not a health care provider covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and are no longer protected by these regulations.

You may revoke this authorization in writing at any time by sending written notification. Your notice will not apply to actions taken by the requesting person/entity prior to the date we received your written request to revoke authorization.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

_____ _____ _____

Signature of Individual or Guardian | Date | Date of Birth

_____ _____

Printed Name | Guardian's relationship to minor

A COPY OF THIS RELEASE OF INFORMATION MUST BE GIVEN TO THE INDIVIDUAL

10/26/2022