DR. SMITH'S PRIOR PATIENTS:

FAX THIS FORM TO: 936.270.4401

Woodlands Arthritis Clinic PA

Dr. Tonya Cockrill, M.D. | Dr. Emily Hung M.D.

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TX 77384

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: _____

Date of Birth: _____ Social Security # _____

This information may be disclosed to and used by Woodlands Arthritis Clinic PA from the following group/individual:
To: Houston Methodist Rheumatology Associates
Address: 17189 Interstate 45 South Medical Office Building 2, Suite 505
City: The Woodlands State: TX ZIP: 77385
Office: 936.270.4400 FAX: 936.270.4401 Medical Records: 713-394-6428

Please release the following:

[x] All Medical Records of DR. Holly Smith Purpose of Use or Disclosure: Continuity of Care

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 behavior or mental health services, and treatment for alcohol and drug abuse.

[x] **YES**, I consent to the release of this information. [ ] **NO**, I do not consent to the release of this information

I understand that the information released is for the specific purpose stated above. Any other use of this information without written consent of the patient is prohibited.

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 **Woodlands Arthritis Clinic PA**. I understand that this revocation will not apply to information already released in response to this authorization. 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 expires in one year. I understand that authorizing the disclosure of this health information is voluntary.

_____ _____

PRINTED NAME of Patient or Legal Representative Date

_____ _____

SIGNATURE of Patient or Legal Representative Relationship to Patient