AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This authorization is meant to comply with and satisfy the requirements of the Health Insurance Portability and Accountability Act ("HIPAA"), Title 45, Part 160, et seq. of the Code of Federal Regulations. Pursuant to these laws, the undersigned states as follows:

Section I. PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
SOCIAL SECURITY#:	DATE OF BIRTH:	

Section II. VOLUNTARY AUTHORIZATION TO RELEASE MEDICAL SERVICES RECORDS

I, _____, voluntarily authorize G.A. Samman, M.D., P.A. d/b/a Clear Lake Cardiovascular Consultants, a Texas Professional Association (the "Association"), its agents, servants, employees, officials, and attorneys to release all of my Medical records (*i.e.*, documents, x-rays, imaging, test results, and all other forms of media, electronic or otherwise), maintained by the Association to Bahaeddin Shabaneh, M.D. and Southeast Houston Cardiology, a Texas Professional Association ("SEHC").

Section III. DESCRIPTION OF INFORMATION AUTHORIZED FOR RELEASE

Y **Entire Medical Record**

If you would NOT like any of the following sensitive information disclosed, check the applicable box(es) below:

Q Alcohol/Drug Abuse Treatment/Referral
Q HIV/AIDS-related Treatment
Q Sexually Transmitted Diseases
Q Mental Health (Other than Psychotherapy Notes)

Section IV. NAME AND ADDRESS OF PERSONS OR ORGANIZATION TO RECEIVE PATIENT'S HEALTH INFORMATION

Bahaeddin Shabaneh, M.D. and
Southeast Houston Cardiology, a Texas Professional Association
530 Orchard Street
Webster, Texas 77598

Section V. PURPOSE OR RELEASE

Please provide the purpose for the use or disclosure: Transfer of all Medical Records for continuation of care by Dr. Shabeneh and SEHC**.**

Section VI. EXPIRATION DATE

Please provide a date or event upon which you wish this authorization to expire: **None.**

If you fail to specify an expiration date or event, this authorization will expire one year from the date it was signed.

Section VII. RIGHT TO REVOKE

I understand that I may revoke or withdraw this authorization, in writing, submitted at any time by submitting a revocation to the Association, except to the extent that the Association has already used or disclosed the requested protected health information in reliance on my authorization.

Section VIII. PHOTOCOPIES OF AUTHORIZATION

I agree that a photocopy of this form will have the same effect as the original.

Section IX. TIME AND CHARGE FOR PHOTOCOPIES OF RECORDS

I understand that the Association will provide copies of my Medical Records to Dr. Shabaneh and SEHC within 15 days of the receipt of (i) a written request for same, signed by me; and may charge a reasonable fee as determined by the PA pursuant to the Texas Medical Board Rules. For paper copies, the PA may charge no more than $25 for the first twenty pages and $.50 per page for every page thereafter. For electronic copies, the PA may charge no more than $25 for 500 pages or less and $50 for more than 500 pages. The PA may charge no more than $8 per copy of an imaging study.

Section X: PATIENT'S RIGHT TO REFUSE SIGNATURE AND OBTAIN COPIES

I understand I am entitled to inspect or copy the protected health information to be used or disclosed. I understand I have the right to refuse to sign this authorization and I am willing to sign this authorization.

Section XI. PATIENT'S/AUTHORIZED REPRESENTATIVE'S SIGNATURE AND DATE

SIGNED on this the_____day of_____, 2017.

_____
Patient/Authorized Representative Signature

_____
Printed Name

NOTE: If the person signing this form is an authorized personal representative's signature, please provide a description of such representative's authority to act for the individual below:

_____

_____

_____