THS Medical Clinic
400 Hwy 90 East
Dayton, TX 77535

Patient Authorization for Use and Disclosure of Protected Health Information

I give full permission for ________________________________ to be able to view, request or sign for my medical records at THS Medical Clinic when I am not or can not be present.
***If there is no one you wish to appoint in the above stated, please sign your name.*

This authorization permits THS Medical Clinic to use and/or disclose the following individually identifiable health information about me. The information will be used or disclosed for the following purpose:

If disclosure is 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 _____________________.

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 THS Medical Clinic. 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 re-disclosure 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:

THS Medical Clinic PA
108A North Main St
Dayton TX 77535

_______________________________________ _______________________
Patient/Legal Guardian Signature Relationship to Patient

_______________________________________ _______________________
Print Patient's Name Date