DR. HUNG'S PRIOR PATIENTS: FAX THIS FORM TO: 936.266.8534

ATTENTION: SARAH LEE

Woodlands Arthritis Clinic PA

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

129 Vision Park Blvd, Suite 211A

Shenandoah, TX 77384

936-273-3900 (office) / 936-273-3901 (fax)

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: Baylor St. Luke's Medical Group Address: 6363 San Felipe, Suite 150

City, ST: Houston, TX Zip: 77057 Phone/Fax: 713.972.8900/ FAX: 936.266.8534

Please release the following:

[x] MOST RECENT CLINIC NOTE OF DR. EMILY HUNG

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