St. Michael Medical Clinic
12609 Louetta Road ◆ Cypress, Texas 77429 ◆ Phone: 281-655-5100 ◆ Fax: 281-655-1415

Authorization for Release of Protected Confidential Health Information

Patient (Last, First) _____ DOB(mdy): _____

I authorize **St. Michael Medical Clinic** to release to ☐ Father ☐ Mother ☐ Spouse ☐ _____

Person: _____

Address: _____

Phone: _____
information and records regarding my treatment, medical and/or behavioral health conditions. I understand that I may revoke this authorization in writing at any time, except to the extent that caption has been taken in alliance on it. I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-healthcare provider, the release information may no longer be protected by federal or state privacy regulations.

Patient/Guarantor Signature: _____ Date: _____

SMC Staff Witness: _____

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