ALOIS PAULS, M.D.
CAROLYN ROBINSON-COWLEY, FNP-BC
2675 41st ST SE, Suite 102
Paris, Texas 75462
Phone: 903-739-7700 | Fax: 903-739-7989

PATIENT AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY/PROVIDER OF CARE

I,____, understand **Alois Pauls, M.D., Carolyn Robinson-Cowley FNP-BC**, and the office staff are authorized by me to disclose my Protected Health Information the manner(s) that I have checked below and to the people that I have listed below.

I wish to be contacted in the following manner: (check all that apply):

Home Telephone: ____

____OK to leave message with detailed information.

____Leave message with callback number only.

Work Telephone: _______________________________________

____OK to leave message with detailed information.

____Leave message with callback number only.

Written Communication

____OK to mail to my home.

____OK to mail to my work/office.

____OK to fax to this number

Other: ____

Name(s) of person(s) authorized by this form to disclose my protected health information:

Name(s) & Relationship(s):

______________________________________ ( ) Medical information ( ) Appt/Testing

______________________________________ ( ) Medical information ( ) Appt/Testing

______________________________________ ( ) Medical information ( ) Appt/Testing

______________________________________ ( ) Medical information ( ) Appt/Testing

<u>I understand that I have the right to revoke anyone listed on the authorization and must fill out the form before the revocation can be completed.</u>

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All revocations must be sent to Alois Pauls, M.D., to the attention of the Privacy Officer, and are not effective until received by the Privacy Officer.

I fully understand and accept the terms of this authorization in accordance with my HIPPA rights.

____ ____________________________________
PATIENT'S SIGNATURE DATE

Authorization added to the patient's medical record on: _________________
Authorization verified by____on_____________________