***

D. Lee Howell, Jr., MD * Terah C Isaacson, MD * Chitra N Sambasivan, MD
Phone: 832.942.8350 * Fax: 832.553.2796
www.bayoucitysurgical.com

REQUEST FOR THE DISCLOSURE AND USE OF PROTECTED HEALTH INFORMATION

I, ____

(Print First, Middle Initial and Last Name, DOB and current telephone number)

Consent to and authorize:

____

____

(Print Name or person or facility, address, and telephone number)

To furnish to Bayou City Surgical Specialists, PLLC, the following medical records and information:

____

(Reason for release of records)

I understand this authorization may be revoked in writing at any time unless it's already acted upon. To revoke this authorization I must send a request in writing to:

Bayou City Surgical Specialists, PLLC
15015 Kirby Dr. Suite 201
Houston, TX 77047

This authorization expires on:

____

(Date or Event)

Or within one (1) year of the date signed if I have not provided an expiration date or event.

I authorize the release of my records: (initial one)

_____ Only records originated prior to today's date (not including today's date)
_____ Records originated both before and after today's date (including today's date)
_____ Records originated only after today's date (including today's date)

I understand that my information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and would no longer be protected by the Privacy Regulations. A copy of this authorization shall be considered as effective and valid as the original.

***
D. Lee Howell, Jr., MD * Terah C Isaacson, MD * Chitra N Sambasivan, MD
Phone: 832.942.8350 * Fax: 832.553.2796
www.bayoucitysurgical.com

Signature of Patient or Authorized Representative. If Representative, please also include relationship to patient:

Signature	Date	Relationship to Patient

7580 Fannin St. Suite 303
Houston, TX 77054

15015 Kirby Dr. Suite 201
Pearland, TX 77047