Serenity GYN & Functional Medicine
220 N Park Blvd
Grapevine, Texas 76051
(817) 280-9616

Authorization of Use and Disclosure of Protected Health Information (1 of 2)

Appointment Reminders: The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are made by telephone and a brief non-specific message may be left on voicemail of the phone number you provided. If you do not approve of these methods and would like alternative reminder methods, please indicate those methods in the space provided (samples of appointment reminders are available upon request): We do not email appointment reminders.

How would you like to be contacted regarding appointments, treatment and /or other information pertinent to your healthcare and/or payment for your healthcare provided at Serenity Gyn & Functional Medicine (Check all that apply)

____Regular Mail ____Home Telephone ____Work Telephone

____Cell Phone

Other:
____

If you have an answering machine or voice mail, may we leave messages regarding appointments, treatment test results and/or other pertinent information regarding your healthcare and/or payment for your healthcare provided at this office.

____Yes ____No ____N/A

If "NO", how else may we contact you regarding this information?

____

Please list any other restrictions regarding messages or reminders regarding your healthcare:

____

Please list any other medical providers or a Primary Care Physician where you would like your healthcare information to disclosed:

____

Telephone Number:______________ **Fax Number: ___________________**

Other Uses and Disclosures: Disclosure of your health information or its use for any purpose other than those listed in the "Notice of Privacy Policies and Practices" brochures and/or consent requires your specific written authorization. If you change your mind after authorizing the use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision. You have the right to request restrictions on use and disclosure of your health information.

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I would like the following restrictions regarding the use and disclosure of my health information:

____

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Persons Authorized to Receive Information:

Health information Miriam Torres, M.D. collects or receives about you may be disclosed to the following persons:

____
Name of Person / Relation / Organization

____
Name of Person / Relation / Organization

Use and Disclosure of Information:

____I authorize the person(s) listed above to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Serenity GYN & Functional Medicine.

____I do not authorize the following information to be disclosed to any other parties except to me as the patient (Please Specify):

____

Right to Terminate or Revoke Authorization: You may revoke or terminate this authorization by submitting a written revocation of Miriam Torres, M.D. You should contact the PRIVACY OFFICIAL or other authorized representative to terminate this authorization.

Patient Signature: _________________________________Date: _______________