Kennington & Associates
21638 State Highway 249, Building D.
Houston, Texas 77070
Fax 832-553-2977

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

I. Patient's Name __X____________________________________ DOB______X__________________________

ID Number ___X___________________________________ Phone Number _________________________

II. Please check one and provide the requested information:

__X_______ I hereby authorize the Kennington & Associates to disclose my Protected Health Information to the following organization(s) and/or person(s):

Name ___X____

Address____

Phone Number: _X__________________ Fax Number: __________________________

_________ I hereby authorize ____ to disclose my Protected
(Primary Care Physician or other Health Care Provider)
Health Information to Kennington & Associates.

III. I authorize the following information to be disclosed:
DATE(S)

__x_All____

IV. Purpose of the Requested Disclosure: Please check one and provide the requested information.

_____ Other ___coordination of treatment_____________________________________

I understand that I have a right to revoke this authorization at any time. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my Protected Health Information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that Kennington & Associates may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I further understand that if the persons(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and would no longer be protected by federal privacy regulations.

I agree that a copy of this release or fax of this release shall be as valid as this original release. If I authorize Kennington & Associates to fax the information, I realize there are inherent risks in faxing Protected Health Information.

This authorization expires upon_____12/24_________

X ____ X ___________________________

Signature of Patient Date