WOMEN'S HEALTHCARE ASSOCIATES

1315 St. Joseph Pkwy, Suite 1818
Houston, TX 77002
Phone 713-654-8128
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George T. Kuhn, M.D., F.A.C.O.G.
Jenna Sassie, M.D.,F.A.C.O.G.
Lalanica Chandrasekera, D.O.

Weilie Tjoa, M.D., Ph.D, F.A.C.O.G.
Jessica Rhinehart-Ventura, M.D.
Diana Herrera, M.D.

AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION

By signing this form, I authorize you to use and disclose the protected health information below.

TO: _____

Patient name: _____

DOB: _____ SS#: _____

The health information you may release subject to this authorization is as follows:

_____

_____

Release my protected health information to the following persons(s)/entity:

_____ **George T. Kuhn, M.D., F.A.C.O.G.**

_____ **Jenna Sassie, M.D., F.A.C.O.G.**

_____ **Weilie K. Tjoa, M.D., Ph.D., F.A.C.O.G.**

_____ **Jessica Rhinehart-Ventura, M.D.**

_____ **Jessica Rhinehart-Ventura, M.D., F.A.C.O.G.**

_____ **Diana Herrera, M.D.**

_____ _____ (Outside Physician)

The reason(s) or purposes for this release of information are as follows:

_____

This authorization shall be in force and effective until the following event and/or date:

_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person at the practice:

George T. Kuhn, M.D., F.A.C.O.G. (*Privacy officer*)
1315 St. Joseph Parkway, Suite 1818, Houston, TX 77002. Telephone: 713-654-8128 Facsimile: 713-654-7426

I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative Date