MEMORIAL OFFICE
9230 Katy Freeway, Suite 410
Houston, TX 77055
P: 281-556-6622 F: 281-647-7767

KATY OFFICE
18400 Katy Freeway, Suite 320
Houston, TX 77094
P: 281-647-7766 F: 281-647-7767

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MEDICAL INFORMATION RELEASE AUTHORIZATION - (HIPPA)

Patient Name: _____ DOB: _____

I hereby authorize Premier Oncology Consultants, PA. to release information regarding my protected health information to the following persons and/or agency. I also give my permission to Premier Oncology Consultants, PA. to communicate information regarding my appointment time or any possible changes to my scheduled appointment to the persons listed below.

Emergency Contact: (Individual we will call should you have an emergency such as a sudden injury or illness while in our care.)

(Emergency Contact / HIPAA)	(Relationship)	(Phone – Required)

☐ By checking this box, I do NOT authorize the release of my HIPAA information to my Emergency Contact.

Additional HIPAA Authorizations:

Name:	Relationship:	Phone (optional):

Premier Oncology Consultants, PA. may contact me personally:

Messages May Be Left At These Numbers: ☐ Cell ☐ Home ☐ Work

Patient Information

I have the right to revoke this authorization at any time by notifying Premier Oncology Consultants, PA. in writing. This authorization will not expire until then. The revocation will not apply to information that has already been released in response to this authorization. Information obtained by individuals on this authorization may be subject to redisclosure by the recipient(s).

Signature: _____ **Date:** _____

****If Signed by a Legal Representative, Relationship to Patient:** _____