2636 S Loop W, Suite 135
Houston, TX 77054
713-500-2800
713-839-0683 fax
LF@uth.tmc.edu

Authorization for the Use and Disclosure of Protected Health Information

(For Lactation Foundation Patients to request Lactation Foundation send medical records to self, another provider, or outside entity)

1. I hereby authorize Lactation Foundation (LF) to use and disclose protected health information from the records of:

   Patient Name – Mother (Print): ____ Birth Date: _________________

   Patient Name – Infant (Print): ____ Birth Date: __________________

2. Copies of the following records shall be used and disclosed:
   ___ Complete Clinical Records
   ___ Other (specifically identify exact information to be disclosed, including **dates of service**)
   ____
   ____
   ____

3. I understand that the records used and disclosed pursuant to this authorization form may include information relating to: Human Immunodeficiency Virus (“HIV”) or Acquired Immunodeficiency Syndrome (“AIDS”); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

4. I understand that copies of the records indicated above will be: (check one or more, as applicable)

   ___ Sent to: Name of Recipient: ____________________
   Name of Company: ____________________
   Address: ____________________
   City: ____________ State: ________ Zip Code: __________

   ___ Faxed to: Name of Recipient: ____________________
   Name of Company: ____________________
   Fax Number: ____________________
   Office Phone Number: ____________________
   faxes sent to doctors' offices only

5. I understand that to the extent any Recipient of this information, identified above, is not a “covered entity” under Federal or Texas privacy law, the information may no longer be protected by Federal and Texas privacy law once it is disclosed to the Recipient and, therefore, may be subject to re-disclosure by the Recipient.
6. I understand that the purpose(s) of the requested use and disclosure is (are): ____
   ____
   ____
7. I understand that I may revoke this authorization in writing at any time except to the extent that Lactation Foundation has already relied on this authorization. I understand that I may revoke this authorization by sending or faxing a written notice to 2636 S Loop W, Suite 135 Houston, TX 77054, 713-839-0683 fax.
8. Unless otherwise revoked, this authorization will expire on the 180th day of the signing or as otherwise specified below:
   ____
9. I understand the Lactation Foundation may not condition treatment on my completion of this form.

Signature of Patient or Patient's Legal Representative: ____ Date: _________________

Printed Name of Legal Representative (if any): ____

Representative's Authority to Act for Patient: ____ (include copy of legal documents)