



West Houston
Internal Medicine Associates PA,

Karen Thampoe, MD
705 South Fry Road, Suite 105
Katy, Texas 77450

281-500-8176
866-650-4586 toll free
281-500-8178-(f)
www.whima.net

**AUTHORIZATION FOR USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

Patient's Name: _____

Patient's Phone Number: _____

I hereby authorize West Houston Internal Medicine Associates PA., assigns and heirs to use and disclose my individually identifiable Protected Health Information (PHI) in the manner described below. I understand that my PHI may be re-disclosed by the person or entity receiving my PHI from West Houston Internal Medicine Associates PA. assigns and heirs, and that it then may no longer be protected by federal privacy regulation. I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form.

This authorization covers the following PHI:

Category of PHI

Medical Records	Claims/Billing information	Mental Health Records
Drug / Alcohol Abuse	HIV & Hepatitis Test Results	Genetic Test Results

Amount of PHI Authorized (please check and answer option 1 or 2):

- Entire PHI (all categories noted above unless otherwise specified by patient below) _____
- Please limit use and disclosure of my PHI to: _____

-----[Examples- "Laboratory results from July 1998"; "Mental health record from January 2001 to present"]

The recipient (s) of my PHI is: West Houston Internal Medicine Associates PA., assigns and heirs.

I authorize my PHI to be used and disclosed at my request for all medical purposes.

This authorization will expire: **AT THE PATIENTS'S VERBAL OR WRITTEN REQUEST**

I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying West Houston Internal Medicine Associates PA., assigns and heirs in writing. I understand that my revocation or modification of this authorization will not affect any action taken by West Houston Internal Medicine Associates PA., assigns and heirs, in reliance of this authorization before West HoustonInternal Medicine Associates PA., assigns and heirs, receives my request for revocation or modification. I must sign my written request and send it to:

Karen Thampoe, MD
705 South Fry Road, Suite 105
Katy, Texas 77450

Signature: _____

Date: _____