Simple Traditions Family Health PLLC
Paul Dibble MD, Shelbie Hveem PA-C
827 S Magnolia Blvd, Suite 6
Magnolia, TX 77355

Ph: 281-259-7400
Fax: 888-502-3566
www.stfhealth.com

Authorization to Use or Disclose My Health Information

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization

I authorize _____to disclose the following health care information (check all that apply):

☐ Records for the past year, a medication list, and a summary page of medical history (if applicable)
☐ My health information relating to the following treatment or condition: _____
☐ My health information for the date(s):_____
☐ Other:_____

You may disclose this health information to:

Name (or title) and organization: Simple Traditions Family Health PLLC, Paul Dibble MD, Shelbie Hveem PA-C

Address: 827 S Magnolia Blvd, Suite 6 City: Magnolia State: TX Zip: 77355

Reason(s) for this authorization (check all that apply):

X for continuity of health care
☐ other (specify)_____
_____

This authorization ends: ☐ on (date) _____
☐ when the following event occurs _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study.
  or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from the office.
  or
- Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____ _____
Patient or legally authorized individual signature | Date | Time

_____ _____
Printed Name if signed on behalf of the patient | Relationship (parent, legal guardian, personal representative, etc.)