DAVID S. LIBSON, M.D.
OBSTETRICS • GYNECOLOGY • INFERTILITY

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I authorize the use or disclosure of health information about me as described as follows:

1. My medical records and information from David S. Libson, M.D., 421 E. 7th Street, Odessa, Texas 79761.

2. Person or class of person authorized to receive the information:

____

____

3. Description of information that may be used or disclosed:____________________

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4. The information will be used or disclosed for the following purposes:___________

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5. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described previously may be redisclosed and no longer protected by these regulations.

6. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

7. I understand that I may revoke this authorization in writing at any time by notifying Dr. Libson's office.

8. This authorization expires 14 days from date of signature.

______________________________ ______________
Signature of Patient or Representative Date

____
Patient's Name

______________________________ ______________
Name of Personal Representative (if applicable) Relationship to Patient

421 EAST 7TH STREET ODESSA, TEXAS 79761 TELEPHONE (915) 333-2900