KOALA HEALTH AND WELLNESS, INC.
1600 SMITH ST. STE 4225
HOUSTON TX 77002

713-652-9777

Patient Authorization to Use/Disclose PHI

Standard Authorization of Use and Disclosure of Protected Health Information

Information to Be Used or Disclosed

Our office will use your contact information to remind you of appointments scheduled or required. This may be done through email, texting, and/or phone calls. On occasion we may be photographing while you are in the office for treatment. In the event that you are in the shot we will ask your permission before posting the picture in our office or on social media.

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by doctors and staff of Koala Health and Wellness.

Please list the names and relation of anyone that you will allow our staff to speak to regarding your treatment and/or appointment times:

_____, _____, _____, _____.

Expiration Date of Authorization

This authorization is effective through _____ unless revoked or terminated by you or your personal representative.

Patient Rights

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and contacting the Privacy Officer.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

I understand this office will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

If you understand and agree with all of the above policies, please sign your name below.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Print Staff's Name / Staff's Signature	Date