SHAYA
PRECISION
HEALTH

Tayma S. Shaya M.D FAAFP
www.shayahealth.com
info@shayahealth.com
16605 Southwest Freeway #350
Sugar Land, TX 77479
P 281-201-2230
F 281-215-5092

**Patient Authorization to Use or Disclose Protected Health Information (PHI)**

I give permission to Shaya Precision Health to disclose and release my PHI as described below:

**Purpose and to whom information can be released: (choose all that apply)**

- ◯ Treatment/continuing medical care with another provider
- ◯ Referral/prescription authorization
- ◯ Billing/claims (example-lab or radiology authorizations)
- ◯ Insurance (ex medical, life, disability)
- ◯ Legal Purposes (ex adoption or employment paperwork)
- ◯ Disability/ FMLA paperwork
- ◯ School physical/forms
- ◯ Other (specify) _____
- ◯ Name (relationship) _____

**Specific information to be disclosed:**

- ◯ Medical Record from (insert date) _____ to (insert date) _____
- ◯ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, vaccination, radiology studies, films, referrals, consults, billing, insurance, and records received from others.
- ◯ Other:_____

**Include: (Indicate by initialing)**

_____ ◯ Drug, alcohol or substance abuse records

_____ ◯ Mental health records (except psychotherapy notes)

_____ ◯ Communicable diseases (including HIV and AIDS) results

_____ ◯ Genetic information (including genetic testing results)

**This authorization shall be effective until (Check one):**

- ◯ All past, present, and future periods, OR
- ◯ Date:_____unless I revoke it.

(NOTE: You may revoke this authorization in writing at any time to Shaya Precision Health).