Texas Wellness Associates Authorization to Release

10500 Northwest Freeway, Houston, TX 77092
Phone 713-683-9494 Fax 713-957-3535

You may revoke this consent at any time. Revocation must be made in writing, signed by you or on your behalf, and delivered in person or by mail. Our posted privacy policy provides more detailed information about the use and disclosure of your protected health information. You have the right to review our policy before signing this authorization and may obtain a copy by calling 713-683-9494 or 866-683-9494. We reserve the right to amend our privacy policy at any time.

I hereby give consent to Texas Wellness Associates to use and disclose my protected health information only for the purposes I indicate and direct. Information will be released under subpoena from government authorities as prescribed by law.

Patient Name _____

Address _____

City _____ **State** _____ **Zip** _____

Signature _____ **Date** _____

If you are signing as the patient's representative:

Your name _____**Relationship** _____

Informed Consent and Release

Name_____

Address_____

City_____ **State**_____ **Zip**_____

Email_____ **Birthdate**___/_____/_____

Daytime Phone _____ **Evening Phone** _____

I hereby voluntarily consent and grant permission to The Texas Wellness Associates, INC., and its employees, providers, agents, contractors, representatives, and assignees to perform venipunctures for the purpose of blood testing. I understand that a trained technician will perform the procedure. I consent to the release of information necessary to perform tests to the laboratory. The results will be kept confidential. I understand the data derived from the tests is preliminary only, and does not constitute a diagnosis, and that I am solely responsible for obtaining a consultation with my physician to determine the importance of the tests. I hereby, fully and unconditionally, forever release and hold harmless employees, providers, agents, contractors, representatives and assignees, (individually and collectively, Releasees), from any and all liabilities, claims, omissions, in connection with the drawing of my blood, laboratory testing of my blood or any specimen, the date derived from such testing, or the dissemination of such data. I hereby understand and agree that this release includes, without limitation, any act or omission that is, or may be any form of negligence on the part of any of the Releasees.

Signature_____ **Date**___/_____/_____

Please check desired test:

_____Wellness Profile ____Other _____

_____Health Profile