AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PLEASE NOTE: THIS FORM MUST BE FILLED OUT IN ITS ENTIRETY TO BE VALID.

I, THE UNDERSIGNED, DO HEREBY AUTHORIZE YOU TO RELEASE THE MEDICAL RECORD OF:

_____ _____ _____

NAME DATE OF BIRTH SS#

FROM: _____ TO: _____

_____ _____

_____ _____

RELEASE TO THIS FAX NUMBER: _____

INFORMATION TO BE RELEASED (REPORTS MAY INCLUDE INFORMATION ABOUT DRUG/ALCOHOL, PSYCHOLOGICAL OR COMMUNICABLE DISEASES INCLUDING HIV STATUS):

( ) OFFICE NOTES, CORRESPONDENCE
( ) LAB, X-RAY AND OTHER TEST REPORTS
( ) REQUESTED REPORTS, NARRATIVES, FORMS
( ) MAY VERBALLY COMMUNICATE ANY MEDICAL INFORMATION REQUESTED

RECORDS FROM ALL DATES WILL BE RELEASED UNLESS OTHERWISE NOTED HERE: _____

REASON FOR RELEASE (REQUIRED BY TEXAS REVISED CIVIL STATUTES):

( ) RELEASE TO ANOTHER PHYSICIAN
( ) INFORMATION REQUESTED BY AN INSURANCE CARRIER
( ) DISABILITY CLAIM
( ) SELF- FOR PATIENT'S OWN RECORDS
( ) OTHER: _____

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN IN RELIANCE ON IT. I FURTHER UNDERSTAND THAT THERE MAY BE A CHARGE FOR PREPARING THE INFORMATION TO BE RELEASED. APPLICABLE CHARGES ARE IN KEEPING WITH GUIDELINES ISSUED BY THE STATE BOARD OF MEDICAL EXAMINERS.

SIGNATURE _____ DATE _____

WITNESS _____ DATE _____