AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned do hereby authorize the release of information from medical records of:

_____ _____

Patient Name Date of Birth

FROM: _____ TO:

_____

_____

_____

_____

_____

_____

Phone:

_____

Fax:

_____

Information to be released: (Reports may include information on drug/alcohol/psychological/

Communicable disease treatment.)

_____ History and Physical _____ Consultation

_____ Laboratory _____ EKG

_____ X-rays _____ Progress Notes

_____ HIV/AIDS _____ All Medical Records

_____ Other

Dates of Treatment: _____

Reason for Release of Information:

_____ Application for Insurance

_____ Worker's Compensation

_____ Change of Physician

_____ Other _____

(Article 4495b, Section 5.08(j) Texas revised Civil Statues requires that an authorization for release of medical records includes" the reason and purpose for the release.)

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 and that, in any event, this authorization expires automatically ninety(90) days from the date of signature.

Date: _____ Signature: _____

_____ _____

Name (printed) Relationship to patient