AUTHORIZATION FOR RELEASE OF INFORMATION

Expires: ______________________

Name of Patient: ____ Date of Birth: _______________________

I the undersigned, hereby authorize a release of protected health information for the above specified patient, according to the guidelines specified below.

Information Released From: Information Released To:

Information to be released will include drug and alcohol/mental health/ communicable disease information, including HIV test results and AIDS related information, if any: (check all that apply) Dates of service: (optional) ___________________________

_____ Release of entire medical record
_____ Consultation Reports
_____ Laboratory Reports
_____ Radiology Reports
_____Operative Reports
_____ Other ____________________________________

_____ Pre-insurance Physical
_____ Pre-employment Physical
_____ Drug Screen

The reason for the release of information. (Be specific. Any other use is forbidden) ____________________________________

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(Article 4495b, Section 5.08 (j) Texas Revised Civil Statures requires that any authorization for release of medical records include "the reason or purpose for the release" of information.)

I understand that these records are confidential and cannot be disclosed without written authorization except as otherwise provided by law. I also understand that the information being disclosed may be subject to re-disclosure by the receiving party, and may no longer be protected. I understand that the treatment or payment cannot be conditioned on signing this authorization, except in certain circumstances such as participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization at any time by notifying the Doctor's office in writing, except to the extent that the action has been taken in reliance in it and that, in any event, this authorization will expire 180 days from the date of my signature unless otherwise specified by date, event or conditions as follows:

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The releasing party, its employees, officers and my attending physician(s) are released from legal responsibility or liability for the release of this information to the extent indicated and authorized herein.

____ Signature of patient or authorized legal representative

_______________________________ Date

____ Relationship to Patient

________________________________ Witness Signature

This facsimile may contain PRIVILEGED, CONFIDENTIAL AND/OR OTHERWISE PROTECTED INFORMATION intended only for the use of the addressee. Unauthorized distribution or use of the facsimile or its contents is strictly prohibited. If you are not the addressee, the person responsible for delivering this message to the addressee, or have received this facsimile in error, please immediately notify us by telephone at the number above and destroy this information. Thank you.