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 Coverage
______Worker's Compensation
______Change of Physician
______Other____

(Article 4495b, Section 5.08 (j) Texas revised Civil Statutes requires that an authorization for release of medical records include "the reasons 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:____________________________

____

Relationship to Patient