Authorization to Release Medical Information

Date: ____

To release the information from the medical record of: ____

Patients Date of Birth: ____________________________ Social Security #: _____________________________

I Authorize:	To Release Information To:
Facility / Dr. Name: ____________________________________	Name: Dr. Claire Brenner, Dr. Debbie Bridges, Dr. Vimon Seriburi
Address: ____	Address: 2241 Peggy Lane – Suite E. Garland, Texas 75042
____	Phone: 972-494-1155
Phone: ____	Fax: 972-494-6572
Fax: ____	

Dates of Treatment / Service: ____

For the purpose of review / examination / continuation of care, I authorize you to provide the following information:

☐ Complete Copy of Medical Records (including psych & HIV/AIDS information)

χ Limited copy of records including only:

____

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This authorization will expire 60 (sixty) days from the date signed. I understand that I may revoke this authorization, in writing, at any time except to the extent that action has been taken in reliance thereon. I understand that if I am releasing this information to an entity or individual not covered by HIPPA, this information is no longer protected by HIPPA. I also understand that the written revocation must be signed and dated with a date that is later then the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Patient / Legal Guardian's Signature: ____

Relationship to Patient: ___________________________________ Date: ___________________________________