## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

## NAME OF PATIENT OR INDIVIDUAL

Last		First	Middle	
DATE OF BIRTH	Month	Day	Year	
ADDRESS				
CITY		ST	TATEZIP	
PHONE ()				
EMAIL ADDRESS (C	Optional):			
I AUTHORIZE THE	STATE ZIP    STATE ZIP   DDRESS (Optional):   STATE ZIP   DDRESS (Optional):   STATE ZIP   DDRESS (Optional):   STATE ZIP   DDRESS (Optional):   STATE			
N				
Street Address				
City, State, Lip				
rax #				
		MEDICAL INFORMATION?	<i>:</i>	
601 CLARA BARTON	Ń BLVD., SUITE 35	0		
GARLAND, TX 75042		0		
Phone: 9/2-420-9900	Fax: 9/2-420-989	9		
want released. If all he	aim information is to	) be released, then check only th	he first box.	
☐ All health informa	tion			
□ Progress Notes		□ Diagnos	□ Diagnostic Test Reports	
□ Pathology Reports		□ Radiolo	□ Radiology Reports & Images	
☐ History/Physical Ex	cam	□ Lab Res	sults	
□ Consultation Repor	ts	□ Other_		
FEEE/TIVE TIME I	DEDIOD This outh	orization is valid until the earli	ior of the death of the individual or the individual	
			iei of the death of the individual, of the individu	
			ion at any time by giving written notice stating	
intent to revoke this a	authorization to the	person or organization named	ed under "WHO CAN RECEIVE AND USE	
			reliance on this authorization by entities that	
=	=		atment based on a failure to sign this authoriz	
SIGNATURE AUTH	ORIZATION: I h	have read this form and agree	to the uses and disclosures of the informatic	
described. I understan	nd that refusing to sig	gn this form does not stop discl	closure of health information that has occurred	
		and the state of t	5 m s - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 m s - 1 g - 1 m s - 1 g - 1 m s - 1 m s - 1 g - 1 m s - 1 m s - 1 g - 1 m s - 1 m s - 1 m s - 1 m s - 1 m s - 1 m s - 1 m s - 1 m s - 1 m s - 1 m s - 1 m s - 1 m s - 1 m s - 1 m s - 1 m s - 1	
SIGNATURE XSign	ature of Individual are In	ndividual's Lagally Authorized Denge	esentetive DATE	
		•	CSCHIAUVC DAIE	
Printed Name of Legal	ly Authorized Kepre	sentative (if applicable):	- Guardian - Other	