

Authorization for Release of Medical Information

I hereby authorize the release of information from the medical record of:

Patient Name: _____
Date of Birth: _____
Social Security No.: _____
Phone Number: _____

Information Release TO:

G. DeAn Strobel, MD
230 E. Evergreen St.
Sherman, TX 75090
Phone: (903) 957-0275 Fax: (903) 957-0279

Information Release

FROM: _____

Please release the following:

- | | |
|--|--|
| <input type="checkbox"/> Problem List | <input type="checkbox"/> X-ray/CT/MRI reports |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> X-ray/CT/MRI films |
| <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> EKG Reports |
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Other Diagnostic Reports _____ |
| <input type="checkbox"/> Immunizations | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Pap Smears or Pathology Reports |

Please include information (if applicable) pertaining to: mental health, drug/alcohol use, HIV/AIDS, communicable disease treatment.

Purpose or need for disclosure of medical information:

- | | |
|---|--|
| <input type="checkbox"/> Continued patient care | <input type="checkbox"/> Personal use |
| <input type="checkbox"/> Attorney/Legal reasons | <input type="checkbox"/> Insurance Claim/Application |
| <input type="checkbox"/> Disability Determination | <input type="checkbox"/> Other _____ |

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified.

Signature of Patient or Legal Representative Date

Relationship to Patient Witness

COMPLETE THIS SECTION ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT

I understand that my medical records may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.

I will not hold G. DeAn Strobel, MD PA, liable for any misinterpretation of the information in my medical record as a result of my not consulting the physician for the correct interpretation.

Signature of Patient or Legal Representative Date

Relationship to Patient Witness
Date request completed _____ # of pages copied _____ Initials _____