AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Phone (512) 338-4404 Fax (512) 338-4405

I, ____, agree to release my medical records from (party sending records):

____

____

To, (the party that is to receive the records):

____

____

This information is being disclosed for the following purpose(s) of:

____

____

I understand that this information may contain information relating to: (check if applicable)

____ Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus)

____ Mental Health ____ Alcohol and/or Drug Abuse

____

(DATE)

____

(PATIENT SIGNATURE)