

**PHYSICIANS' CENTER, P.A.**

3721 WILLIAMS DRIVE • GEORGETOWN, TEXAS 78628  
PHONE 512-869-7310 • 512-930-9130 • FAX 512-869-5616

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I, \_\_\_\_\_, \_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
(Name of Patient) (Date of Birth) (Phone No.)

authorize \_\_\_\_\_  
(Name of Organization making disclosure) (City) (State)

to release information to: \_\_\_\_\_  
(Name of Person or Organization receiving information)

Address, City, and State of Person or Organization receiving information

• The information shall be released by: \_\_\_\_\_ Mail \_\_\_\_\_ Pick-Up \_\_\_\_\_ Other

• The type of information to be disclosed (check all that applies):

Visit Date Visit Date

- \_\_\_\_\_ Office Notes \_\_\_\_\_ EKG Tracings \_\_\_\_\_
- \_\_\_\_\_ Pathology Report \_\_\_\_\_ X-Rays \_\_\_\_\_
- \_\_\_\_\_ Emergency Room \_\_\_\_\_ Lab Reports \_\_\_\_\_
- \_\_\_\_\_ Alcohol/Drug Report \_\_\_\_\_ Mental Health \_\_\_\_\_

HIV Test Results \_\_\_\_\_  
(Requires your signature here)

• The purpose of the disclosure is (check one):

- \_\_\_\_\_ Consultant/Specialist \_\_\_\_\_ Payment of Claim/Benefits
- \_\_\_\_\_ Transfer of medical Care \_\_\_\_\_ Insurance Application
- \_\_\_\_\_ Legal Investigation \_\_\_\_\_ Personal Use
- \_\_\_\_\_ Disability Determination/DVR
- \_\_\_\_\_ Other (Please specify) \_\_\_\_\_

• I understand that in accordance with State and Federal Confidentiality regulations the information disclosed may include reference to all my medical treatment.

• \_\_\_\_\_  
Signature of person giving consent Date consent is signed

• The signature is of the:

- \_\_\_\_\_ Patient \_\_\_\_\_ Parent of Minor \_\_\_\_\_ Legal Guardian
- \_\_\_\_\_ Patient's Executor or next of kin
- \_\_\_\_\_ Person Authorized by Patient \_\_\_\_\_