Texas Rheumatology

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Authorization to Release Medical Information

Patient Name: _____ Date of Birth: ____/____/____

Previous Name: _____

I hereby authorize **Texas Rheumatology** to release healthcare information of the patient named above to:

Name of Provider/Clinic/Hospital: _____

Address: _____ Phone: _____

_____ Fax: _____

This request and authorization apply to:

- ○ All healthcare information, including HIV/AIDS and mental health information.
- ○ Health information related to the following treatment/condition/dates:

  _____
- ○ Only Diagnostic Studies (Lab/Radiology/Biopsy/etc.):

  _____

This authorization is valid for 12 months after the date signed. I understand that except for actions already taken, this authorization may be voided by me at any time. This authorization may be revoked by written communication to Texas Rheumatology.

_____ Date: _____
Signature (Patient/Parent/Guardian/Legal Representative)

_____ Date: _____
Employee Signature