

Please complete the areas marked. Thank You.

SOUTH OAKS FAMILY MEDICINE, P.A.

AUTHORIZATION FOR
RELEASE OF INFORMATION

I, the undersigned, do hereby authorize Dr. _____ to release the information described below from the medical records of:

* (Patient Name) *

* (Date of Birth) *

* (Social Security #) *

* From: Dr. _____
South Oaks Family Medicine
7900 FM 1826, Bldg. 2, Ste. 240
Austin, Texas 78737
Fax# 512 462 9765

* To: Dr. _____

* Information to be released: (Reports may include information on drug/alcohol/psychological/communicable disease treatment).
___ History and Physical ___ Consultation ___ Laboratory ___ EKG
___ X-rays ___ Progress Notes ___ Other ___ All Medical Records
___ Communicable Disease ___ All Medical records requested/received on my behalf from other medical providers regarding my medical history and treatment.

* HIV/AIDS. I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS, if any, with the rest of my medical records. Initial: _____ Date: _____

Date of Treatment: _____

Reason for Release of Information:

* ___ Application of Insurance Coverage ___ Worker's Compensation
___ Change of Physician/Relocation of Physician ___ Other (please specify)

I understand that I may revoke this consent at any time except that action has already been taken in reliance on it and that, in any event, this authorization expires automatically ninety (90) days from the date of signature, unless written revocation is received by the physician prior to that date.

* Signature: _____

* Date: _____

Representative or person legally authorized to sign

Relationship to Patient (State reason patient is unable to sign).