Authorization for Release of Information

PATIENT NAME: _____
LAST FIRST MI

DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY# _____-_____-_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ ALTERNATE PHONE: _____

EMAIL ADDRESS: _____

I hereby authorize Sonja Kristiansen, M.D. to release information from my medical record as indicated to:

NAME: _____

ADDRESS: _____CITY_____

STATE: _____ ZIP: _____ PHONE: _____ FAX: _____

INFORMATION TO BE RELEASED:

	Dates:
o History and physical exam	_____
o Progress notes	_____
o Lab reports	_____
o X-ray reports	_____
o Other: _____	_____

I specifically authorize the release of information relating to HIV (AIDS related testing) _____
Initial

PURPOSE OF DISCLOSURE:

- o Changing Physicians
- o Consultation/Second Opinion
- o Legal
- o Continuing Care
- o Other (specify) _____

1) **I understand that this authorization will expire 90 days after I have signed this form**
2) **I understand that I may revoke this authorization at any time by notifying the providing organization in writing.**
3) **I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient an no longer be protected by Federal privacy regulations.**
4) **I understand that in compliance with the Texas Medical Board Rules, Chapter 165.2, I will pay a fee of $25.00 for the first 20 pages then $0.50 per page thereafter. Records will be released within 15 business days after payment. Duplicate copies will result in duplicate fees.**
5) **Records will only be sent via fax or by conventional mail. The patient may also pick them up in person.**

_____ _____
Signature of Patient or Authorized Representative Date

FOR OFFICE USE ONLY

DATE FEE COLLECTED: _____ AMOUNT $_____ BY:_____

DATE RECORDS RELEASED: _____ □ MAILED □ FAXED □ PICKED UP BY PATIENT