1900 S. Coulter St.
Suite B
Amarillo, TX 79106

PATIENT MEDICAL RELEASE FORM

Patient's Name :____(please print)

Social Security Number: __________________________Date of Birth: ____________________

By signing this form I authorize you to disclose my individually, identifiable health information as described below, which may include information concerning communicable diseases, such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental Illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment or any other such related information. I understand that any disclosure of information carries with it the potential for a unauthorized re-disclosure and the information may not be protected by the Federal and Share privacy regulations. I understand that my healthcare and the payment of my health care will not be affected if I do not sign this form.

Information to be released to:
Estelle Archer
1900 Coulter Suite B
Amarillo TX 79106
Phone: (806) 350-7312
Fax: (806) 356-0045

Information to be released from:
____
____
____
____
____

Information to be releases: (check everything that applies)
___History/Physical Exam Notes
___Laboratory Results
___MRI Reports
___Other Diagnostic Reports
___Prescription History
___ Other (please specify ____

Reason for release of information:

____

ANY OTHER USE OF THIS INFORMATION WITHOUT WRITTEN CONSENT OF THE PATIENT IS PROHIBITED

I understand that the information release is for the specific purpose stated above. I further understand that I may revoke this consent (in writing) at any time except that action has been taken in reliance on it. This consent will expire one (1) year after the date of my signature, unless otherwise specified.

____ __________________________________

*Signature of patient or patients legal representative** *Date*
(Please attach supporting documentation for legal representative)