Rosa C. Gonzalez, M.D. P.A.
3560 Delaware, Ste. 109
Beaumont, Texas 77706
Office: 409-892-9347
Fax: 409-892-8803

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____

DOB: _____ SSN: _____

I, _____ authorize **Rosa C. Gonzalez, M. D.**, located at 3560 Delaware, Suite 109, Beaumont, Texas 77706 to disclose the following protected health information to _____.

___ Medical Records/Notes
___ Laboratory work
___ Psychological testing
___ Speak with Teacher/Counselor/Diagnostician
___ Speak with Doctor / Psychologist / Therapist
___ School testing results
___ Billing records / Other

_____ I understand that Dr. Rosa Gonzalez will receive compensation for the use or disclosure of my health information. The arrangement has been explained to me and I understand and accept it.

_____ I also understand that no disclosure of my records can be made without my written consent unless otherwise provided for in state and federal regulations.

_____ Such disclosure is for the purpose of patient continuity of care.

Specification of the date, event, or condition upon which this consent

Expires: _____

_____ _____
AUTHORIZING PARTY SIGNATURE STAFF or WITNESS SIGNATURE

_____ _____
PRINTED NAME DATE PRINTED NAME DATE