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 RECORDS

Patient Name: _____

DOB: _____ SSN: _____

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

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

_____ I understand that if the person or organization that receives my information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.

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

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

Expires: _____ unless I choose to revoke it.

AUTHORIZING PARTY DATE PRINTED NAME DATE

RELATIONSHIPE TO CLIENT DATE WITNESS DATE