AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Date _____ **Social Security #** _____

Patient Name _____ **Date of Birth** _____

Address _____ **City, State, Zip Code** _____

Patient's Home Phone _____ **Patient's Cell Phone** _____

I, _____, hereby authorize Pearl Medical Clinic to receive ☐ or ☐ disclose information from the abovenamed patient's medical records, including laboratory results, radiologic testing results, medications, hospitalization information, office notes, and treatment plans for the purpose of _____

I understand that this authorization will expire in 90 days, and that it may be revoked at any time in writing. I further understand that continued treatment of the above-named patient is not contingent upon receipt of this information. Also, the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the HIPPA privacy rule.

Please send the requested information to:

Pearl Medical Clinic
2727 Bolton Boone Drive. Suite 103
Desoto, TX 75115
Phone: 469-453-2008 Fax: 469-449-0286

Specific records being requested:

_____

_____

_____

Patient/Legal Guardian Signature: _____ **Relationship:** _____