AUTHORIZATION TO RELEASE PATIENT INFORMATION

1. **Patient's Full Name:**_____

2. **Patient's Date of Birth:**_____ **Patient's Social Security No.:**_____

3. **I authorize** _____ **to disclose protected health information identified in section (4) below: See 45 CFR §164.508(c)(1)(ii)**

4. **I request that the following health information be released: See 45 CFR §164.508(c)(1)(i)**

   Date(s) of Treatment Requested: _____ **Date of Injury:** _____

   Check the box(es) which best describe the information to be released and disclosed.

   □ **Physician Office/Progress Notes** □ **Laboratory Reports** □ **Radiology/X-Ray Reports** □ **All Records**
   □ **Medication/Prescription Records** □ **Consent Forms** □ **Echo Reports** □ **Billing Records**
   □ **Other**_____
   _____

5. **I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), psychological or psychiatric treatment, behavioral or mental health services, and alcohol and drug abuse. I authorize the release or disclosure of this type of information.**

6. **I request that the health information be released and disclosed to: See 45 CFR §164.508(c)(1)(iii)**
   Name: **BEHR LAW FIRM (or its designated representative)**
   Address: **1920 Corporate Dr., Ste 108A** **Fax:** **(888) 400-5260**
   San Marcos, TX 78666 **Telephone No.: (512) 353-5555**

7. **The purpose or reason this information is needed: (check all that apply) See 45 CFR §164.508(c)(1)(iv)**

   □ **Legal Purpose** □ **Insurance** □ **Personal Use** □ **Medical Care** □ **Military** □ **School**
   □ **Social Security Disability** □ **Workers Compensation** □ **VA Medical Center**
   (Social Security, Workers Comp. and VA Medical Center requests require documentation of pending claim.)
   □ **Other**_____
   Name of Attorney or Insurance Company:_____

8. **I understand the following: See 45 CFR §164.508(c)(1)(i-iii)**
   a. **I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.**
   b. **The information released in response to this authorization may be re-disclosed to other parties and no longer protected.**
   c. **My treatment, payment for my treatment and enrollment or eligibility for benefits cannot be conditioned on the signing of this authorization.**
   d. **I may be charged a reasonable fee for copies of these medical records according to State and Federal Laws.**

9. **This authorization will expire One Hundred Eighty (180) days from the date signed below. See 45 CFR §164.508(c)(1)(v)**

_____ _____
Signature of Patient or Legally Authorized Representative See 45 CFR §164.508(c)(1)(vi) **Date Signed**

Address: _____

_____

_____ _____
Relationship of Legally Authorized Representative to Patient See 45 CFR §164.508(c)(1)(iv) **Telephone Number**