

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address: \_\_\_\_\_ City/State \_\_\_\_\_

I hereby authorize \_\_\_\_\_

Address \_\_\_\_\_

to release copies of my medical records in their possession, concerning my illness, treatments, or recommendations while I was a patient at their facility, during the date (s) of \_\_\_\_\_

I understand that my medical record MAY contain reference to, or results, of: HIV antibody (AIDS) testing, testing or treatment, for mental health problems, testing for, or treatment of, drug or alcohol use or abuse.

I further authorize of such confidential information to the indicated party.

**Those records are to be released to: Chun W. Tan, M.D.**  
**1901 HWY 97 E., Suite 210**  
**Jourdanton, Texas 78026**  
**Fax to 830-769-3278**

Attn: \_\_\_\_\_

I request the following information to be released:

\_\_\_\_\_ Entire Medical Record

\_\_\_\_\_ Progress Notes

\_\_\_\_\_ X-Rays or EKG Reports

\_\_\_\_\_ Lab Reports

\_\_\_\_\_ Pathology Reports

\_\_\_\_\_ Day Surgery

\_\_\_\_\_ Other Specify: \_\_\_\_\_

The purpose for releasing this information is:

\_\_\_\_\_ Further medical care

\_\_\_\_\_ 3<sup>rd</sup> party reimbursement

\_\_\_\_\_ Other Specify: \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness