

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

I hereby authorize:

NAME/FACILITY: _____
ADDRESS: _____
TELEPHONE# _____

To release the following information from the medical record of:

(Patient Name) _____ (Birth Date) _____

INFORMATION MAY BE RELEASED ONLY TO THE FOLLOWING PARTY(S):

Roger Knapp M.D.
480 W. Southlake Blvd, Suite 133
Southlake TX 76092

817-329-9234

The specific purpose(s) for this disclosure is/are:

- [X] sharing with other healthcare providers
[] other (please describe) _____

[] I WANT [] I DO NOT WANT (check one) you to INCLUDE information pertaining to the diagnosis and/or treatment of HIV testing, AIDS, psychiatric illness, and alcohol and/or chemical abuse and dependency if any.

SPECIFIC INFORMATION TO BE RELEASED: (Please check all that you are requesting by released)

- Complete Medical Record for this Office
History & Physical
Other (Please List)
Immunization Records Only
Diagnostic Testing & Results

- I understand that I may revoke this authorization at any time by notifying the office in writing at ATTN: Practice Manager, Medical Record Request of my intent to revoke this authorization, and that such revocation will not have any effect on any actions taken by the office before the revocation.
I understand this authorization expires 180 days from the date signed, unless otherwise revoked.
I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
I understand that I may be asked to show proof that I have the authority to sign an authorization to review and/or receive copies of the above named patient's medical record which I am requesting.
I understand that a photocopy or facsimile of this authorization is as valid as the original.

Date _____ Signature of Patient, Parent or Legally Authorized Representative _____

Printed Name _____ Relationship to Patient _____