Authorization To Release/ Obtain Health Care Information

Patient's Name: _____ **Date of birth:** ___/___/___

I, the undersigned, hereby authorize Lee Family Practice Associates to:

_____ Receive the following information _____ Send the following information

To/From: _____

_____

_____

Phone: _____ **Fax:** _____

To/From: Lee Family Practice Associates, P.A.
William O. Lee, MD
4 Oaktree Street
Friendswood, TX 77546
Phone: (281) 482-5551 Fax: (281) 482-0995

_____Health information relating to the following treatment, condition, or dates of treatment
_____All health information
_____Other: _____

I understand that this authorization is valid for 90 days after the date of my signature, Information document in my medical record after the date of my signature will not be released. I have the right to revoke this authorization at any time with the understanding that all or part of this information may have been used in good faith. I understand that this authorization authorizes the release of medical records including, but not limited to, records concerning psychiatric, drug, or alcohol abuse and communicable diseases, such as human immunodeficiency virus (HIV) and/or acquired immune deficiency syndrome (AIDS).

The use of the information may be protected by public law 93-255, Section 33 or federal regulation 42 CFR, Part 2. The information provided is confidential and any disclosure by the receipt is prohibited without written consent.

Patient's Signature: _____ Date: _____
Parent/Legal Guardian: _____ Date: _____
Witness:_____ Date: _____