KATRINA L. LEE, M.D., P.A.

MEDICAL RECORDS AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

By State Law you must be advised that:
The information you authorized for release may include information that should be considered information about communicable diseases, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency virus, also know as Acquired Immune Deficiency Syndrome ("AIDS").

PATIENT NAME	BIRTHDATE
SOCIAL SECURITY NUMBER	TREATMENT DATES
PATIENT ID	HOSPITAL NUMBER

I hereby authorize: (Specific Doctor, Hospital, and/or Clinic):
Katrina L. Lee, M.D., P.A.
6124 W. Parker Rd., Bldg. 3, Ste. 430
Plano, TX 75093
Telephone: 972-981-7980 FAX: 972-981-7981

to release the following health record(s) information of the above named patient, covering the period(s) indicated for the following purpose:

( ) Insurance Payment
( ) My Doctor's Use
( ) Referral Care
( ) Transfer of Care
( ) Other _____

The information that is to be released:

( ) Pap Smear/Biopsy Results
( ) Operative Report(s)
( ) Prenatal Records
( ) History & Physical Exam
( ) Lab / Pathology
( ) X-Ray Reports
( ) Consultations
( ) All Records
( ) AIDS/HIV Test Results
( ) Mental Health Records
( ) Drug Abuse Treatment Records
( ) Other _____

This information is to be released to:

Name:_____

Address:_____

Telephone:_____ FAX:_____

I understand this consent can be revoked at any time except that disclosure made in good faith has already occurred in reliance on this consent. Without prior revocation this authorization will automatically expire one year from this date.

I am also informed that health records will be released to the person(s) or organization(s) named above, to those persons or organizations I have authorized by other releases granted and to persons or organizations authorized by law.

Witness Signature Date	Patient Signature Date
Reason Patient Unable to Sign	Person Authorized to sign for Patient
Date Sent	Relationship to Patient