

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):

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

- | | |
|--|---|
| <input type="checkbox"/> Insurance Payment | <input type="checkbox"/> Transfer of Care |
| <input type="checkbox"/> My Doctor's Use | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Referral Care | |

The information that is to be released:

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

This information is to be released to:

Name: Katrina L. Lee, M.D., P.A
Address: 6124 W. Parker Rd., Bldg. 3, Ste. 430
Plano, TX 75093
Telephone: 972-981-7980 FAX: 972-981-7981

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	