Advanced Rheumatology of Houston

Offices of Dr. Tamar F Brionez

Authorization for Disclosure of Confidential Information

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Patient Name_____

Address _____

Date of Birth _____ SSN_____

Authorizes: Name of Person/Facility _____

Address or Fax Number_____

To release the following medical information to **Advanced Rheumatology of Houston.** Check All that May be released:

History	Lab Reports	Operative Report	Psychological Reports
Physical	X-ray	Care Plan	Progress Notes
EKG Report	Therapy Reports	Other (specify) _____	

Note: Memorial Hermann patients must initial the following statement:
"I acknowledge and hereby consent to such that the released information may contain alcohol, drug abuse, psychiatric, HIV Testing, HIV results, or AIDS information" INITIAL HERE _____

This authorization covers patient care rendered from_____ to _____ (dates)

Purpose of Disclosure:

Medical Care Insurance Attorney Other (specify) _____

The authorization shall be valid for ninety (90) days from the date of signature below, unless revoked in writing by the patient prior to that expiration.

The patient agrees that a photocopy of this authorization may be considered valid. El Yes El No

Patient Signature: _____ Date: _____