

# Advanced Rheumatology of Houston

Offices of Dr. Tamar F Brionez

## Authorization for Disclosure of Confidential Information

10857 Kuykendahl Rd Suite 160

The Woodlands, TX 77382

Office: 281-766-7886

Fax: 281-719-9320

[www.advancedrheum.com](http://www.advancedrheum.com)

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: \_\_\_\_\_