AUTHORIZATION DISCLOSURE OF CONFIDENTIAL INFORMATION

Patients Name: _____ (please print)

Patients Date of birth: _____

Patients Address: _____

Authorizes: _____ (facility/Drs Name)

_____ (address, city, zip)

_____ (phone)

_____ (fax)

To Release the following medical information to:

Clark Brown Family Care Clinic
1033 La Posada Dr. #210
Austin, Texas 78752
phone: (512) 391-9700
FAX: (512) 391-9703

[ ] All chart notes, including labs, imaging, and other special testing reports.

[ ] Information **ONLY pertaining** to a specific date range and/or specific reports/tests from the period of _____ to _____.

*** [ ] I do not want information pertaining to alcohol, drug abuse, AIDS, AIDS related diagnosis or mental health condition released.

Purpose of Disclosure:
[ ] Medical Care
[ ] Attorney
[ ] Insurance
[ ] Other

This medical release form shall be valid for 120 days from the date of signature. The patient can revoke this authorization in writing at any time prior to the expiration date.

Patient Signature _____

Date _____

*** PLEASE MAIL OUT OF MORE THAN 40 PAGES ***