2721 FM 2718 Cuero, TX 77954
361-233-1151
www.drzmedicalclinic.com

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Date: _____

To: _____ FAX: _____

Patient Name: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____

I, _____ , hereby authorize _____ to receive or disclose information from the above named patient's medical records, including laboratory results, radiologic testing results, medications, hospitalization information, office notes, and treatment plans for the purposes of _____

I understand that this authorization will expire in 30 days, and that it may be revoked at any time in writing. I further understand that continued treatment of the above named patient is not contingent upon receipt of this information. Also, the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the HIPAA privacy rule.

Please send the requested information to:

To: Zengerle Medical Clinic

Address: 2721 FM 2718

City: Cuero State: Texas Zip Code: 77954

Phone: 361-277-6800

Fax: 361-277-6801

Specific records being requested:

_____

_____

_____

_____

_____

_____

Signature of Patient or Legal Guardian

Relationship