Magnolia Family Medicine

6912 FM 1488, Suite A, Magnolia TX 77354 P- 281-356-1945 F- 281-356-1978

Authorization for: ( ) Release (x) Request
of Protected Health Information

Patient Name	**Date of Birth**	**SS#**
Address		**Telephone #**

I herby authorize _____to release information from the medical record of :

_____

To: Feras Elhajj, MD Christian Dyhianto, MD
Name of person/organization to which disclosure is to be made

6912 FM 1488, Suite A Magnolia TX
Address of person/organization to which disclosure is to be made City State

Fax # 281-356-1978 Phone# 281-356-1945

For treatment dates: _____
Specify dates-this like **MUST BE** completed
For the following purpose: (x) Medical Care ( ) Legal ( ) Insurance ( ) Other (detail below)

Select Portions

0 Office Visit Progress Note	0 Registration Summary	0 Entire Record *Including*
0 Immunizations	0 Entire Record	HIV Testing Only
0 EKG	0 Entire Record *Excluding*	0 Entire Record *Including*
0 Lab	HIV & Chemical Dependency	Chemical Dependency only
0 Imaging/Radiology	0 Entire Record *Including*	
0 MD Orders	HIV & Chemical Dependency	0 Other _____

This authorization is valid until 180th day after the date is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked and cover only treatment (s) for the dates specified above.

_____(*initials*) I acknowledge , and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.

I, undersigned, have read the above and authorize the above authorized staff to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I herby releases and hold harmless the above named facility and it's parent company from all liability and damages resulting from the lawful release of my Protected Health Information.

_____ _____ _____
Date Signature of Patient/Parent/Conservator/Guardian Authority/Relationship to Patient

Fees/charges will comply with all laws and regulations applicable to release of Protected Health Information
Payment is due at time of release