Authorization for Release of Information

I hereby authorize:

_____

_____

_____

to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any other such related information. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

_____ _____

Patient Name (please print) Date of Birth

_____

Patient Address (City, State and Zip) Phone Number

_____

Specific Date(s) of Service (if known) All Dates of Service

_____

Patient Signature

Information to be released: (Check all that apply)

- **Complete Medical Records**
- Radiology Reports
- Pathology Reports
- Visits & Encounters
- Laboratory Reports
- Consultation Reports
- Operative Records
- Other: _____

_____

The health information described herein shall be **released to**:

Serenity GYN & Functional Medicine
Dr. Miriam Torres
220 N. Park Blvd #100 Grapevine, Tx 76051
(817)280-9616-office (817)280-9870-fax