



Authorization for Release of Information

I hereby authorize:

Miriam M. Torres, M.D.
220 N. Park Blvd., #100
Grapevine, TX 76051 817-280-9616

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 Date

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:**

