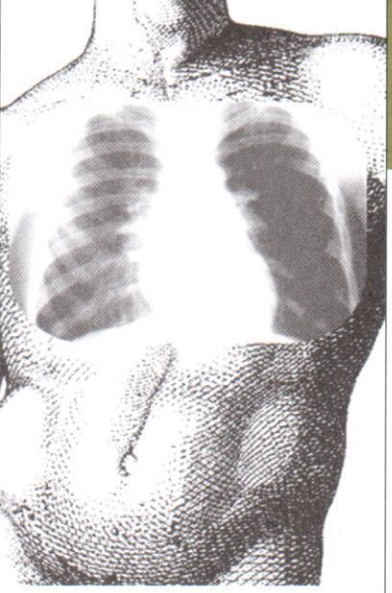

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Diplomates of the Board of Internal Medicine,

Pulmonary & Critical Care Medicine.

Sleep Disorders Medicine & Allergy.

MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my health information, to the person(s) on entity listed below.

I hereby authorize_____to release the following from the health records of

Pt.Name_____

DOB_____ SSN_____

Information to be released:

____ Copy of completed records
____ History and Physical/Consultation reports
____ Laboratory, Radiology, PFT, ECHO, Venous Doppler
____Information related to HIV testing results
____ Other_____

Information to be released to:

Name:_____

Address: _____

City/State/ZIP: _____

Phone: _____Fax:_____

Information to be released for the purpose of:
Medical Care Legal Insurance Other (detail) _____

Signature: _____Date: _____
Patient or Representative

_____
Relationship

_____Date:_____
Witness

I understand that you will provide this information within 15 Day from receipt of request and that a fee of preparing and furnishing this information may be charged according to rulling set forth by the Texas State Board of Medical Examiners. I understand that the information released for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.