Jamison C. Alexander, DO

Obstetrics and Gynecology

3401 N. Calais Street, Suite B, Sherman, TX 75090. Phone (903) 892-8222. Fax (903) 892-8444.
www.alexanderobgyn.com

Authorization for Release of Medical Information

I hereby authorize the release of information from the medical record of:

Patient name:_____ Date of Birth:_____

SSN:_____ Daytime phone:_____

Information **TO:**

_____

_____

_____

Information **FROM:**

_____

_____

_____

Please release the following information:

__Problem List
__Progress Notes
__History/Physical Exam
__Lab/Pap Reports
__Immunization Record
__X-Ray Reports/Mammography
__X-Ray Films
__EHG Reports
__Other:_____
_____

Purpose for record disclosure:

__Continued Patient Care
__Legal/Attorney
__Disability Determination
__Personal Use
__Insurance Claim/Application
__Other:_____

I understand that the information released is for the specific purpose as stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke/resend this consent (in writing) at any time except to the extent that action has been taken in reliance to it. This consent will expire 90 days after the date of my signature unless otherwise specified.

_____

Signature of Patient or Legal Representative Date

_____

Relationship to patient (if not patient) Witness