RED RIVER FAMILY PRACTICE, LLP

Michael E. Killian, M.D. Cynthia Brinson, M.D. J. Eric Lambeth, M.D.
Gary L. Werntz, M.D. Mary Bartz, M.D. Steven B. Hutto, M.D.

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ **Date of Birth:** _____

Previous Name: _____ **Social Security #:** _____

I request and authorize the following Entity or Person:

Name: _____

Address: _____

City: _____ ***State:*** _____ ***Zip Code:*** _____

Phone#: _____ ***Fax#*** _____

to release the following Requested, Initialed and Signed, Healthcare Information to:

RED RIVER FAMILY PRACTICE
900 E. 30th St., Suite 300
Austin, TX 78705
Phone: 512-476-6555 Fax: 512-476-5611

[___] Healthcare Information relating to the following treatment, condition or dates:

_____

[___] All Healthcare Information ***Including release of drug, alcohol or mental health treatment, STD results as defined by law, RCW 70.24 et seq., HIV/Aids testing,*** whether negative or positive to the person(s) listed above. I understand the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

[___] Other: _____

Signature: _____ **Date:** _____

If this Authorization is being signed by a personal representative, describe the representative's

Authority to act for the individual: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.