Authorization for Release of Medical Information

I hereby authorize the release of information from the medical record(s) of:

Patient Name: _____DOB: _____
Social Security No.: _____Phone: _____

Information Release TO: **G. DeAn Strobel, MD, PA**
230 E. Sycamore Street, Suite 200
Sherman, TX 75090
Phone: (903) 957-0275 Fax: (903) 957-0279

Information Release FROM:

_____
_____
_____
_____

Please release the following:

- **____Problem List**
- **____Progress Notes**
- **____History & Physical Exam**
- **____Lab Reports**
- **____Immunizations**
- **____Operative Reports**
- **____Other _____**
- **____X-ray/CT/MRI reports**
- **____X-ray/CT/MRI films**
- **____EKG Reports**
- **____Other Diagnostic Reports _____**
- **____Pap smears or pathology report**
- **____All records**

Please include information (if applicable) pertaining to: mental health, drug/alcohol use, HIV/AIDS, and communicable disease treatment.

Purpose or need for disclosure of medical information:

- **____Continued patient care**
- **____Attorney/Legal reasons**
- **____Transfer of care**
- **____Personal use**
- **____Insurance Claim/Application**
- **____Other_____**

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on 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 **Witness**

_____
COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT

I understand that my medical records may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.

I will not hold G. DeAn Strobel, MD PA, liable for any misinterpretation of the information in my medical record as a result of my not consulting the physician for the correct interpretation.

Signature of Patient or Legal Representative **Date**

_____
Relationship to Patient **Date request completed** **# of pages copied** **Witness Initials**