**AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION**

Please REQUEST medical information FROM:

Primary Care Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Address, Phone and Fax number:

Please SEND medical information TO:

Clinic/Physician: Bryan M. Lowery, M.D. 5575 Warren Parkway Suite #305 Frisco TX 75034

Phone: 469-200-4802 **Fax: 469-287-7903** Email doctor@friscoconciergemedicine.com

I hereby authorize the above-mentioned provider to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above. I also understand this information may contain information relating to Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV), mental health, and alcohol and /or drug abuse. Release and/or disclose records and information regarding:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ - \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ \_\_\_\_\_ /\_\_\_\_\_\_ / \_\_\_\_\_\_\_

Name of Patient Social Security Number Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address City State Zip Code

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Work Cell

DURATION: This authorization shall become effective immediately and shall remain in effect until \_\_\_\_\_\_\_\_\_\_ (optional: enter date) or for ninety days from the date of signature if no date entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

PLEASE SPECIFY RECORDS TO BE RELEASED AND/OR DISCLOSED: Electronic version is preferred.

\_\_\_\_ Entire medical records \_\_\_\_ History and Physical \_\_\_\_ Chart Summary \_\_\_\_ Labs \_\_\_\_ Radiology \_\_\_\_ Pathology \_\_\_\_ Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request that the health information release and/or disclosed pursuant to this authorization be used for the following purposes only: \_\_\_\_ Physician or Health Care Facility \_\_\_\_ Legal \_\_\_\_ Personal \_\_\_\_ Other

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization. The copy is for me to keep. I understand that there may be a fee for preparing and furnishing this information.

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Signature of patient or legal representative Date Relationship if not patient