*** STAT REQUEST ***

AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

REQUESTING medical information FROM:

_____	_____	_____	_____
Provider Name	**Clinic/Location**	**Phone**	**Fax**

Please SEND medical information TO:

Bryan M. Lowery, M.D. *5575 Warren Parkway Suite #305 Frisco TX 75034*
Phone: 469-200-4802 ***Fax: 469-287-7903*** *Email: carestaff@lowerymd.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 or infection with Human Immunodeficiency Virus, mental health, and alcohol and /or drug abuse. Release and/or disclose records and information regarding:

_____	_____ /_____ / _____
Name of Patient	**Date of Birth**

_____	_____	_____	_____
Address	**City**	**State**	**Zip Code**

_____	_____	_____
Home phone	**Cell phone**	**Email Address**

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.
_***X***__ 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: _x_ Physician or Health Care Facility ____ Legal ____ Personal ____ Other
A copy of this authorization is valid as 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.

_____	_____	_____
Signature of patient or legal representative	**Date**	**Relationship (if not patient)**