Authorization for Disclosure of Confidential Information

Physician, Hospital, Clinic: Jose .F. De Leon, M.D. Address 1330 Prudential Dr. Suite 100
City: Dallas State: Texas Zip: 75235 Telephone: 214-879-3505 Fax: 214-879-3507

I hereby authorize the above physicians, hospital or clinic to disclose my individual identifiable health information as described below including but not limited to information concerning communicable disease such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), chemical or alcohol dependency, laboratory test results, medical history, treatment, or any such related information. I understand that if the recipient authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal and state privacy regulations.

Date: ________________
Patient's Name: ______________________ Date of Birth: _________________
Social Security #: _____________________

Description of information to be released: (check all that apply)

___Health history (DOS __________)
___Lab Report(s) (DOS __________)
___X-Ray report(s) (DOS ________)
___C-Section Op-Report (DOS ______________)
___Clinician/Nurse Notes (DOS _____________)
___ Prenatal Record & Labs (DOS ___________)
___ Research (DOS ____________)
___Pap Report (DOS ___________)
___Immunization Records (DOS _____________)
___Progress Notes (DOS_________________)
___Sonogram Reports (DOS ________________)
___Other Specify: ________________________
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The health information described herein shall be released to:

Physician, Hospital, Clinic: ________________________________
Address: ____
City: _______________ **State:** _____________ **Zip:** _______________
Telephone: _______________________ **Fax:** ____________________

Purpose of Disclosure: ___________ Continuation of Care

Other: ____

I understand that this authorization will expire 180 days from the date of this authorization unless otherwise specified, ____________________________________, whichever occurs first
Expiration event/date

I further understand that I may revoke this authorization at any time by notifying the above physician, hospital or hospital in writing at the corresponding address. I also understand that the written revocation must be dated with a date that is later than the date on the authorization and signed. The revocation will not affect any actions taken before the receipt of the written revocation.

PHOHIBITION OF REDEISCLOSURE: This information is being disclosed to us from records whose confidentiality may be protected by federal law. Federal regulation prohibits us from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A copy of fax transmission of the original is as valid as the original.

This form has been read to me and I understand its meaning ____________
Initials

______________________________________ ______________________________________
Signature of patient or patient's representative Date

______________________________________ ______________________________________
Printed name of patient's representative Relationship to patient

____
Witness