Authorization for: ( ) Release ( ) Inspection ( ) Amendment of Protected Health Information

Patient Name: _____ Date of Birth:____/____/____.

Social Security: _____-_____-_____.

Name of Healthcare Provider/ Physician/Facility:_____.

Address: _____Telephone#: _____.

I hereby authorize _____ to release information from the Medical record of (Patient Name) _____.

To: Dr. Amber Shamburger M. D.

Address: 225 E. Edgewood Dr. Friendswood, Texas 77546

For treatment Dates: _____ Specify dates-this must be completed

For the following Purpose: ( ) Medical Care ( ) Legal ( ) Insurance ( ) Other

Select Portions

( ) Last Pap ( ) Immunizations ( ) Labs ( ) Imaging/Radiology ( ) Entire Record ( ) Office Visit Progress Notes

This Authorization is valid until the 180th day after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked and covers only treatments for the dates specified above.

___ (Initials) I acknowledge, and hereby consent to such, that the release information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information.

I, the undersigned have read the above and authorize staff to disclose such information as herein contained. I have the right to revoke this authorization writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility from all liability and damages resulting from the lawful release of my Protected Health Information.

Date: _____ Signature of Patient/Parent/Guardian: _____.

Fees/Charges will comply with all laws and regulations applicable to release of Protected Health Information. Payment is due at time of release.