AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

TO: _____

I hereby authorize the following information to be released from the medical record of:

Patient Name: _____
Address: _____
Social Security Number: _____ Date of Birth: _____

This information is to be released to the LAW OFFICE OF WILLIAM T. WILSON, ATTORNEY & COUNSELOR AT LAW, LTD., P. O. Box 427, Temple, TX 76503-0427.

PLEASE CHECK INFORMATION REQUIRED TO BE RELEASED

_____ Clinic Notes	_____ History & Physical	_____ Mammogram Reports	_____ Emergency Room Record
_____ Progress Notes	_____ Discharge Summary	_____ Mammogram Film	_____ Billing
_____ Lab Report	_____ Nurses Notes	_____ EKG, EEG, EMG	_____ Directive to Physician
_____ X-Ray Report	_____ Operative Report	_____ Physician Orders	_____ Other (Specify):
_____ X-Ray Film	_____ Pathology Report	_____ Immunization Record	_____

Including information (if applicable) pertaining to:
_____ Psychiatry/Psychology _____ Drug _____Alcohol _____ HIV/AIDS _____ Genetic Testing

Purpose of Disclosure:
The purpose of the release of medical records authorized hereby is to allow the LAW OFFICE OF WILLIAM T. WILSON, ATTORNEY & COUNSELOR AT LAW, LTD. access to this information in connection with his representation of me.

I understand that to the extent any Recipient of this information, as identified above, is not a "covered entity" under Federal or Texas Privacy law, the information may no longer be protected by Federal and Texas Privacy law once it is disclosed to the Recipient and, therefore, may be subject to re-disclosure by the Recipient.

I understand that I may revoke this authorization in writing at any time except to the extent that the medical provider has already relied on this authorization. I understand that I may revoke this authorization by providing the medical provider a written request for revocation stating my intent to revoke this authorization.

This authorization will expire in 180 days, or at the date or event specified here: _____

I understand that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization, or person.

Any photostatic copy of this authorization shall be as valid and effective as the original.

_____ Date: _____
Signature of Patient

Witness: _____