William G. Brelsford, MD, FACP, FACR
Jan Smith, RN, MSN, FNP-C

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:____

Patient DOB:____________________ Patient SSN:____________________

I hereby authorize and request release of information, medical records including lab reports, surgery reports, X-Ray, MRI, or DEXA reports, or any other necessary information pertaining to my treatment and/or diagnosis.

Information requested **FROM**: William G. Brelsford, M.D., F.A.C.P., F.A.C.R.

PLEASE FAX RECORDS TO NUMBER LISTED BELOW WHENEVER POSSIBLE.

To be sent **TO**: ____

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The information to be disclosed is: ________________________________

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for the purpose of: ____

____.

I understand that my records are protected under Rules 509-510, Texas Civil Rules of Evidence; Articles 4495b and 5561h, Texas Revised Civil Statutes; and Federal Regulations including 42 CFR Part 2. I understand that the specific information to be disclosed may include history of or treatment for alcohol or drug abuse; history of or treatment for Acquired Immune Deficiency Syndrome (AIDS), or other related conditions. I further understand that this consent is subject to revocation at any time in the form of a written notice from me.

______________________________ ____________________

Patient Signature Date Signed

****ANY DISCLOSURE OF INFORMATION BY THE RECIPIENT IS PROHIBITED****

Updated 7-21-10

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