Southwest Orthopedics, LLP.

Dr. Kyle F. Dickson

6560 Fannin Ste.1016, Houston, TX 77030
Phone: (713) 800-1080 Fax: (713) 800-1081

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: *(optional)* _____

I request and authorize Doctor: _____

To release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

☐ **Progress Notes** ☐ **Operative Reports** ☐**Other(Specify)** _____

☐ **Lab Reports** ☐ **Special Studies (EMG, MRI, etc..)**

☐ **Other:** _____

For the Purpose of : ☐ Continuity Of Medical Care ☐ Legal ☐ Insurance ☐ Other Specify)_____

☐ Yes

☐ No

I understand that this authorization is valid for 90 days from the date of my signature. I understand that this authorization authorizes the release of all my medical records. I further understand that I can revoke this authorization in writing at any time prior to the expiration date. In addition, I understand that any release of this information by the recipient without my further consent is prohibited. Finally, I understand that a photocopy of this authorization may be considered valid.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.