AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:

Date of Birth:

This will authorize (facility):
To release general medical, as well as psychiatric/psychological, drug/alcohol abuse and HIV/AIDS testing information from my health record in accordance with the following Statues:

A general medical authorization and subpoena duces tecum, without a specific authorization to release psychiatric/psychological, drug/alcohol and HIV testing information must have this waiver from the patient or his/her empowered representative.

INFORMATION IS TO BE RELEASED TO

CHRISTUS Health – Medication Management Program
1001 ESE LOOP 323, SUITE 260, TYLER, TX 75701
Phone: 1-800-214-7351
Fax: 903-606-1105

___ Discharge Summary
___ History and Physical
___ X-Rays
___ Report of Consultation
___ Operative Report(s)
___ Any Recent Imaging
_X_ Labs, Cultures **(A1C, CMP & LIPID PANEL)**
_X_ Medication History
_X_ Other – Last Diabetes Visit Summary

RECORD IS TO BE USED FOR: Hospital/Clinic Treatment

I understand that I have the right to refuse this authorization and that the facility named above as the releasing facility is released from all legal liability that may arise from the release of information requested.

Prohibition on re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by law. Any further disclosure is strictly prohibited.

This authorization will be valid for ninety days (90) after the date of my signature as it appears below.

Patient Signature: _____ Date: _____

Empowered: _____ Date: _____
Representative Signature

(Relationship to patient: _____)

Witness Signature: _____ Date: _____