AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

I hereby authorize the release of information:

Patient Name	Date of Birth	Social Security Number

Release of records FROM:

Healthcare Provider / Provider / Facility	Telephone Number	Fax Number
Street Address	City, State	Zip Code

Please release requested information to: **LISA KIRK, DO**
318 RICHLAND WEST CIRCLE
WACO, TEXAS 76712
P: (254) 776-8008
F: (254) 776-6892

Please release the following information for these treatment dates: ____

Include this information (if applicable): ☐ Alcohol/Drug ☐ Genetics ☐ HIV/AIDS ☐ Mental Health

PURPOSE:

☐ **Attorney/Legal**	☐ **Continued Care**	☐ **Insurance**	☐ **Personal Use**
▫ Complete Records ▫ Summary information (clinic notes, history & physical, operative reports, pathology reports, consultations, discharge summary) ▫ EKG/EEG/EMG reports ▫ Immunization records ▫ Laboratory reports ▫ Medication records ▫ Nursing notes ▫ Physician orders ▫ Progress notes ▫ Radiology reports **Other:**	▫ Summary information (clinic notes, history & physical, operative reports, pathology reports, consultations, discharge summary) ▫ EKG/EEG/EMG reports ▫ Immunization records ▫ Laboratory reports ▫ Radiology reports **Other:**	▫ Summary information (clinic notes, history & physical, operative reports, pathology reports, consultations, discharge summary) ▫ EKG/EEG/EMG reports ▫ Immunization records ▫ Laboratory reports ▫ Radiology reports **Other:**	▫ Complete Records ▫ Summary information (clinic notes, history & physical, operative reports, pathology reports, consultations, discharge summary) ▫ Billing records ▫ EKG/EEG/EMG reports ▫ Immunization records ▫ Laboratory reports ▫ Medication records ▫ Nursing notes ▫ Physician orders ▫ Progress notes ▫ Radiology reports ▫ Radiology Images **Other:**

This protected health information is disclosed for the following purpose:

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Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from the date of execution at which time this authorization expires.

____
Patient Printed Name or Legal Authorized Representative

____ ______________________________
Signature of Patient or Legally Authorized Representative Date