DOWNTOWN DOCTOR

Dr. Georgeanne Freeman
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Austin, Texas 78703
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AUTHORIZATION FOR RELEASE OF INFORMATION TO US

I, the undersigned, hereby authorize the doctor or medical practice I name below to release the information specified to Dr. Georgeanne Freeman at The Downtown Doctor medical clinic.

Doctor's Name _____

Practice Name _____

Mailing Address _____

_____

Phone Number _____

Fax Number _____

The reason for this release of information is: ☐ Continuity of care

☐ Other (please specify): _____

I understand that my records are confidential and cannot be disclosed without written authorization, except as otherwise provided by law.

This authorization is valid for six (6) months and may be revoked by the patient, orally or in writing at anytime prior to that expiration date.

Information to be released should include all history, physical exam and progress notes, lab and X-Ray reports, and all correspondence relating to my medical care unless otherwise specified below.

Your prompt attention is greatly appreciated.

_____ _____

Patient's Printed Name | Patient's Date of Birth

_____ _____

Signature of Patient or Patient's Legal Representative | Date

According to state and Federal law, the statements below must be signed in order to process your records requests if such information exists in your chart(s).

Please include the following information in my records request:

Mental Health Records _____

Signature of Patient or Patient's Legal Representative

Alcohol/Substance Abuse Records _____

Signature of Patient or Patient's Legal Representative

HIV Records _____

Signature of Patient or Patient's Legal Representative