3270 Joe Battle, Suite #360
El Paso, TX 79938

Phone: 915.351.9000
Fax: 915.351.9041

RELEASE OF MEDICAL INFORMATION

I hereby authorize, **Dr. Lee** and staff, to release or request, any or all of my medical record information:

_____

Name of Doctor, Hospital, Person, Institute, Agency or Self

_____

Street Address City State Zip Code

Phone Number: _____ Fax Number: _____

RELEASE INFORMATION ONLY AS INDICATED BELOW

___ Entire Medical Record
___ Operative Report
___ Laboratory/Pathology Reports
___ Radiology Reports
___ Sleep Study Reports
___ Substance Abuse/Dependency
___ Psychiatric/Mental Health Treatment
___ HIV/AIDS Information
___ Sexually Transmitted Disease Test/Treatment
___ Other _____

___ Verbal Medical Information may be released to the following:

_____

___ **DO NOT** release any medical information to the following:

_____

Patient Name: _____ DOB: _____ SSN: _____
Patient Signature: _____ Date: _____
Witness/Office Staff: _____ Date: _____

PERSON REQUESTING MEDICAL RECORDS OTHER THAN PATIENT

Name: _____ Relationship to Patient: _____
Signature: _____ Date: _____

This consent is effective from today and will expire upon my request. I understand that information used or disclosed pursuant to this Consent may be disclosed by the recipient and may no longer be protected by federal or state law.

If you are transferring your care to another provider, please check appropriate box:
□ Moving out of town □ Dissatisfied □ Other, please explain _____