AUTHORIZATION TO RELEASE MEDICAL RECORDS FROM DR.TRIZNA

I, the undersigned, hereby authorize Dr.Zoltan Trizna to release information from my medical records.

______________________________ ______/______/____________

Patient's FULL NAME (please PRINT) **Date of birth**

The information of the office to which you want the records transferred:

______________________________ (______) _______ - ______________

(Name of the physician) **(Fax number of their office)**

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(Their full mailing address with ZIP code)

Information to be released (please check selected):

[ ] Dermatology records
[ ] Pathology report/s
[ ] Laboratory report/s, including HIV tests if applicable
[ ] Consultation reports
[ ] Mental health records
[ ] Other (please specify): ____

Reason for release of information (Article 4495b, Section 5.08 U) Texas Revised Civil Statutes requires that an authorization for release of medical records include "the reasons or purposes for the release."):

[ ] Second opinion
[ ] Release for continuation of care
[ ] Worker's Compensation
[ ] Application for insurance claim or coverage
[ ] Other (please specify): ___________________________

I understand that I may revoke this consent at any time except to the extent that action has already been taken. This authorization expires automatically 365 days from the date of signature.

____ _____/_____/________

Signature of patient or authorized representative Date