AUTHORIZATION TO RELEASE MEDICAL RECORDS from your doctor/s to Dr.Trizna

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

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

Please mail (do not fax) the records to:

Zoltan Trizna MD, PhD
8500 Bluffstone Cove A101
Austin, TX 78759

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

_____ _____
Relationship to patient (if not patient is signing the form) Witness

_____
Reason patient is unable to sign