SIDNEY T. ROBIN, M.D.

FAMILY PRACTICE

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, do hereby authorize ______________________________ to release information from the medical record of:

_______________________ _______________________ ________-________-________
Patient Name Date of Birth Social Security No.

From: ______________________________

____

____

To: Sidney T. Robin, M.D.
Family Practice
631 W. 38th St., Ste. 1
Austin, TX 78705
Ph: 512.459.4177
Fax: 512.420.0974

Information to be released: *(Reports may include information on drug/alcohol/ psychological/communicable disease treatment).*

History & Physical
Laboratory
X-Rays
HIV/AIDS
Consultation
EKG
Progress Notes
All Medical Records
Other: ______________________________

Dates of Treatment: ______________________________

Reason for Release of Information:

Application for Insurance Coverage
Workers' Compensation
Change of Physician
Other: ______________________________

(Article 4495b, Section 5.08(j) Texas Revised Civil Statutes requires that an authorization for release of medical records include "the reason or purposes for the release".)

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it and that, in any event, this authorization expires automatically ninety (90) days from the date of signature.

______________________________ ______________________________
Signature Date

______________________________ ______________________________
Legal Witness Relationship to Patient *(state reason patient is unable to sign)*