RAFAEL A. RODRIGUEZ, M.D.
INTERNAL MEDICINE
3228 Interstate 30, Suite 220
Mesquite, TX 75150
Specializing an Adults and Senior Citizens
Ph# (972) 216-5400

Authorization to Release Health Information

Patient Name ______________________ **Date of Birth** ______________________

Telephone ______________________ **Social Security** ______________________

I [ ] do [ ] do not (check applicable box) authorize this information to be faxed.
If yes, fax number: **(972) 216-5405**

OR

Mail to: **Rafael A. Rodriguez, M.D.**
3228 Interstate 30, Suite 200
Mesquite, TX. 75150

Facility Name: ____

Phone Number: ______________________ Fax Number: ______________________

This information is being disclosed for the purpose of Continuing Health Care.
For Healthcare Covering the Period(s) [ ] All or From: ______________ To: ______________

Complete Health Record to be disclosed or (check appropriate boxes):
[ ] History & Physical Exam [ ] Progress Notes [ ] Discharge Summary
[ ] X-Rays / Ultrasounds [ ] Laboratory Tests [ ] Consultations
[ ] Other: ____

I understand that specific information to be released may include AIDS or HIV, Alcohol and/or Drug Abuse, and Mental Health.

I understand that if I request copies of records for myself or a member of my family, a review of this information with my physician or other healthcare provider is encouraged.
I understand that if the physician does not feel it is in my best interest, I may designate another healthcare provider to receive these records. I accept responsibility for these copies and information contained herein.

Unless otherwise indicated, this authorization will expire ninety (90) days from the date of signature. The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that this authorization may be evoked in writing at any time, except to the extent that action has been taken in reliance on this authorization for the purposes stated above.

I understand that there may a fee for preparing and furnishing thus information.

______________________ ______________________ __________
Signature of Patient or Legal Representative Relationship to Patient Date