



3201 University Drive East, Suite 425 • Bryan, TX 77802
Telephone: 979-207-7400 • Fax: 979-207-7401 • www.txbsi.com

Authorization for Release of Information

Jonathan A. Friedman, M.D.
Jason M. Hoover, M.D.

L. Gerard Toussaint III, M.D.
J. Bradley White, M.D., Ph.D.

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

I _____ (Print Name of Patient/Individual) hereby authorize

Phone Number: _____ Fax Number: _____

to use and disclose the protected health information as described below to the following person(s) or organization:

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Purpose of Disclosure:

- Continuity of Care Transfer of Care Legal
- Insurance Personal Use Other: _____

The following information may be used and/or disclosed:

Complete Medical Record and /or radiology CD's of any treatment or examination

Signature: _____ Relationship to Patient: _____ Date: / /

This authorization will expire 1 year from the date signed unless the facility receives a Revocation. I understand that I may revoke this authorization at any time by notifying the facility in writing.

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.