Gabriel C. Millar, M.D., P.A.

Pediatric and Adolescent Medicine

AUTHORIZATION FORM

RELEASE OF MEDICAL INFORMATION

Name of Patient ____________ Date of Birth ____________ Social Security # ____________

Address ____________ Phone # ____________

Dates Requested: ____________ TO ____________

INFORMATION TO BE RELEASED*

- o History & Physical
- o Laboratory
- o Progress Notes
- o HIV/AIDS
- o Consultations
- o ALL
- o Radiology/MRI/CT
- o OTHER

If Other, Please Specify: ____________

* Reports may include information on drug/alcohol/psychological/HIV or communicable disease treatment.

PURPOSE OF RELEASE

- o Personal Use
- o Social Security
- o Legal Purposes
- o Disability
- o Insurance
- o OTHER
- o Continuing Medical Care

If Other, Please Specify: ____________

AUTHORIZATION*

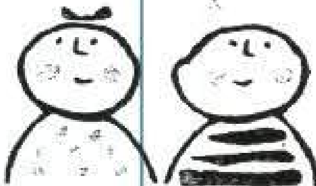
Name of Parent/Guardian/Executor ____________ Relationship to Patient ____________

Signature ____________ Date ____________

*In addition to this authorization, I understand that I may revoke this consent anytime, except to the extent that action has already been made before receipt of revocation. This authorization expires automatically one hundred eighty (180) days from the date of signature or otherwise specified. I understand that I may be charged for copies of my medical records. I understand that these records are protected under federal/state law and cannot be disclosed without my consent otherwise provided by law. Releasing office will not be responsible for dissemination or disclosure of your confidential medical information once we provide such information, at your request, to your health insurer, employer, attorney or other designee.

RELEASING PHYSICIAN

Name of Physician/Facility ____________ Address/Phone/Fax ____________



Gabriel C. Millar, M.D., P.A.
Pediatric and Adolescent Medicine

Gabriel C. Millar, M.D., P.A.
P.O. Box 1255
Round Rock, TX 78680-1255
Phone: (512) 255-7337
Fax: (512) 828-0451