TEXAS FAMILICARE MEDICAL GROUP

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ _____,
(Patient's Name) (Date of birth)

(Consent and authorize the release of my records from: Include Name, Address, City & State)

_____

PHONE#_____FAX #_____
(Hospital or Physician(s)

(Release to) Texas FamiliCare Medical Group, Robert A. Strzinek PhD. D.O.

(Address) 1725 Chadwick Court, Suite 100, Hurst, TX 76054

(Information to be released)_____

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

_____ (Individual or personal rep.'s initials)

These records are required for the following purpose: PCP/Continued Care

Signature_____ Date_____
(Patient or legal representative)