

**PLEASE FILL OUT ALL INFORMATION INCLUDING ADDRESS, PHONE, AND EMAIL, SIGN AND RETURN WITH \$25 PAYMENT. If paying by credit card, give name as it appears on the card, billing zip code, expiration date, and security code.**

**I hereby authorize the use or disclosure of information from the medical record of:**

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**I authorize the following individual or organization to disclose the above named individuals health information:**

**Gary Brewton MD FACP  
PO Box 541565  
Houston TX 77254-1565**

Date(s) of service requested (if known): **ALL DATES** (or, if you wish to limit dates, from: \_\_\_\_/\_\_\_\_/\_\_\_\_ to: \_\_\_\_/\_\_\_\_/\_\_\_\_)

Description of information to be released: **ALL RECORDS** (or, if you wish to limit information, check only those you wish to release)

History/Physical Exam     Progress Notes     Radiology/Imaging Reports     EKG Reports  
 Laboratory Results     Immunization Record     Genetic Testing Information     Other (specify) \_\_\_\_\_

**This information may be disclosed TO and used by the following individual or organization:**

Name (facility/provider receiving information) \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

For the purpose of: **ONGOING MEDICAL CARE** or Other (specify) \_\_\_\_\_

I understand that the information in my health record may include information relating to sexually transmitted disease acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until \_\_\_\_/\_\_\_\_/\_\_\_\_ (date of event)

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.254. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Gary Brewton MD at the address above. We will try to get your records out the next day, but up to 15 working days may be required to process records requests, depending on the number of requests received.

Also, if I provide my credit card information below, I authorize Dr. Brewton to charge the \$25 TMB approved fee to my card.

\_\_\_\_\_  
Signature of Patient/Legal Representative

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Card Type (Amex, MC, VISA)

\_\_\_\_\_  
Credit Card Number

\_\_\_\_\_  
Billing Zip Code

\_\_\_\_\_  
Exp Date

\_\_\_\_\_  
Security Code