Dean Zincone, M.D.
1355 E Court St
Seguin, TX 78155
phone: (830) 401-4401 or fax: (830) 303-5225

Patient will pick up. Date of pick-up ________________

Call when ready (phone #) ________________

Mail Records please________________

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

IMPORTANT: READ ALL INFORMATION & INSTRUCTIONS ON THIS FORM BEFORE SIGNING.

PATIENT'S NAME (Please Print) ________________ FIRST ________ MI ________ LAST ________ Birthdate ________________

Are medical records filed under another name? ________________ Phone Number ________________

Approximate date last seen ________________

I hearby authorize Dr. ________________

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to release Information to: Dean Zincone, M.D. 1355 E Court St., Seguin, TX 78155

Please send the following specific information concerning my illness and/or treatment in your facility: (Specify dates of treatment.)

[ ] All records to include sensitive information such as HIV, substance abuse, etc.
[ ] All records within the last 3 years.
[ ] Any locations. [ ] Main Clinic only.
[ ] Satellite(s) only (specify)________________
[ ] Other: (indicate specific illness, procedure, date(s) of treatment, etc.) ________________
[ ] Records of HIV disease, mental illness, drug/alcohol abuse, and/or sexually transmitted disease treatment.
[ ] X-rays / Films

REASON FOR REQUEST:
[ ] Personal [ ] New Employer [ ] Transfer of Care [ ] Disability [ ] Life Insurance
[ ] Legal Review [ ] Billing Information Only [ ] OTHER (please explain)________________

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I hereby consent to the release of the above information. You are authorized to release to the person or entity above all information or medical records relating to diagnosis, testing or treatment for such disease(s) as specified above. I understand that such information cannot be released without my informed consent. Expires in 90 days.

I hereby release Dr.____________and his staff from all legal responsibility that may arise from this release of information.

I understand that there may be a charge for the retrieval and copying of the above information. I agree to pay for this service.

Cancellation Notice: Rrecords releases are accomplished in as little as 2-3 days, but no longer than 15 days. You have the right to withdraw your authorization. If you choose to do this you must contact our office and immediately sign to withdraw authorization form.

YOUR SIGNATURE BELOW CONFIRMS THAT YOU UNDERSTAND AND AGREE TO THE TERMS OUTLINED.

PATIENT'S SIGNATURE ________________ Date ________________

PARENTAL REQUEST FOR CHILD'S MEDICAL RECORDS

I hereby declare under penalty of perjury, that I am the natural or adoptive parent or legal guardian of said child and there is no court order restricting or prohibiting my access to such medical records.

PARENT OR LEGAL GUARDIAN ________________ Date ________________

Date Completed ________________ by ________________

TO THE RECIPIENT OF THIS INFORMATION: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY STATE LAW. YOU ARE PROHIBITED FROM MAKING ANY FURTHER DISCLOSURE OF IT WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY STATE LAW.