Lee Ann Pearse, MD., P.A.
AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____ who resides at_____
In the city of _____, in the state of _____ hereby authorizes:

Name: _____
(Physician, hospital, clinic, lab, radiology center or other healthcare provider)

Address _____

City, St, Zip _____

To disclose the following specific medical information by ___mail or ___fax

Dr. Lee Ann Pearse, M.D.
7777 Forest Lane, Suite BB141
Dallas, TX 75230
Phone: (972) 566-5622 Fax: (972) 566-5616

From the Health Records of:

Name: _____DOB: _____
(Name of individual whose health record is being disclosed)

Address: _____

City, St., Zip: _____

For the purpose of: _____

My authorization extends only to those date elements/documents Initialed below:

_____ Statements of charges or payments
_____ Records of visits (all visits)
_____ Record of visit for a specific date or dates
Specific dates include or limited to
_____
_____ Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc)
_____ Progress Notes
_____ Photographs, videotapes, digital or other images
_____ Discharge Summary
_____ History and Physical Examination
_____ Consultation Reports
_____ All of the above
_____ Other (Must be specific) _____
_____ Mental Health and/or alcohol and drug abuse treatment
_____ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)
_____ Hepatitis Information

This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization.

2. A photocopy or fax of this authorization is a valid as the original.

3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if note below. The revocation muse be in writing. A revocation form is available from the receptionist.

4. Lee Ann Pearse, M.D., P.A., its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

5. Treatment, payment, enrollment or eligibility for benefits may be conditioned upon obtaining this Authorization.

6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ _____

(Patients name printed) date

_____ _____

(Patients signature or guardian if minor) expiration date
(If other than one year from date above)

_____ _____

Social security number (for ID purposes)

_____ _____

Patients personal representative date

_____

Patients personal representative's authority to act

_____

Witness