Dr. David Walburn

Authorization for Release of Health Information

Patient Name:_____ Date of Birth:_____

Current Address:_____ Phone #:_____

I,_____, hereby authorize:

(PRINT NAME OF PARENT OR LEGAL GUARDIAN)

DAVID WALBURN M.D.
3275 WEST ALABAMA ST.
HOUSTON, TEXAS 77098
713-529-6704 (PHONE)
713-529-6790 (FAX)

____ To Obtain ____ To Release

Name:_____ Phone #:_____ Fax#_____

Address:_____

☐ If more than 8 pages please mail records

☐ Date(s) of Service Requested _____

OR

☐ Full Record Please which may include information relating to communicable disease(s), Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), genetic testing or screening, behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

RESPONSE REQUIRED

Description of the purpose of the use and/or disclosure:

-- Change of Provider	-- Second Opinion	-- Emergency/Acute Care
-- Consultation	-- Insurance	-- Social Security/Disability
-- Legal Purposes	-- Personal Use	-- Other:_____

I have carefully read this consent, understand its contents and authorize the release of the above specified information. I understand this Authorization will remain in effect for one (1) year, but I may revoke it in any time in writing. I further understand that any such revocation will not apply to any information already released under this Authorization. I understand that I am under no obligation to sign this Authorization and that my ability to obtain treatment from Dr. David Walburn will not depend in any way whether I sign this Authorization. I understand that I have a right to receive a copy of this Authorization. I understand that information used or disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient and may no longer be protected by State and Federal privacy regulations. I hereby release Dr. David Walburn from any and all liability related to his reliance upon this Authorization of the release of information to this Authorization.

_____ _____ _____

(Signature of Authorized Party) (Relationship to Patient) (Date)