



Jeffrey A. George, M.D.

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AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

Patient's Name: _____

DOB: _____

Phone #: _____

SS #: _____

Address: _____

I authorize records: (please select one)

To be released **TO** Jeffrey A. George, M.D. from _____

Address: _____

Phone: _____ Fax: _____

To be released **FROM** Jeffrey A. George, M.D. to _____

Address: _____

Phone: _____ Fax: _____

I request release of the **complete health record(s)** for **all dates of service** unless specified here: _____

The purpose of this disclosure is for **treatment/payment/healthcare operations** unless specified here: _____

This authorization gives Jeffrey A. George, M.D. permission to request your medical records from any health care provider that you have received treatment from as specified above for the duration that you have a direct treatment relationship with Jeffrey A. George, M.D. Jeffrey A. George, M.D. is authorized to furnish information even though the confidentiality of the information may be protected by Federal or State laws & regulations. **This includes any and all alcohol &/or drug treatment records or psychiatric records and any information related to HIV or sexually transmitted disease testing or results that are in the record, unless otherwise specified above.** Jeffrey A. George, M.D. is released and discharged from any liability, and the undersigned will hold Jeffrey A. George, M.D. harmless for complying with this information. I understand that I am not required to sign this authorization. I understand that I may revoke this authorization at any time by presenting my written revocation to Jeffrey A. George, M.D., 4510 Medical Center Drive, Suite 210, McKinney, TX 75069. I understand that the revocation will not apply to information that has already been used or released under this authorization. I understand that physician's office has the right under Texas state law to require payment up front for reasonable costs of copying and mailing before furnishing the medical records.

Signature of Patient or Legal Representative

Printed Name of Patient or Legal Representative

Relationship to patient or Legal Representative

Date

Witness

Date

NOTICE TO PERSON OR AGENCY RECEIVING THIS INFORMATION: *This information has been disclosed to you from records whose confidentiality is protected. Laws & regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient.*