CONSENT FOR RELEASE OF INFORMATION

DATE: _____

I hereby authorize _____ to release the following information from the health record(s) of:

Patient Name: _____

Address:_____

SSN: _____ Date of Birth: _____

Covering the periods of care from _____ to _____

Information to be released:

- ☐ **Copy of complete health record(s)**
- ☐ **History & Physical**
- ☐ **Excluding information related to HIV testing and or results**
- ☐ **Other:_____**

Information to be released to:

PEDRO M. ARGUELLO, M.D., P.A.
9190 KATY FREEWAY STE 102
HOUSTON, TEXAS 77055
O: 713-647-9300
F: 713-647-5582

I understand this consent can be REVOKED at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

Specification of the date, event or condition upon which this consent expires:
_____

The facility, its employees and officers and attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Signed: _____ **_____**
Patient or Representative — Relationship to Patient

_____ **_____**
Witness **Date**