Louis E. Ramos, MD

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**AUTHORIZATION TO RECEIVE OR TO RELEASE INFORMATION**

Please be advised that your medical health records constitute privileged information that is protected by the laws of the State of Texas and that they may contain information that is protected under Federal Confidentiality Regulations. These records cannot be disclosed without your written consent unless otherwise provided for in the federal regulations as outlined in the Notice of Privacy Practices. Authorizing the release of information contained in your health records constitutes waiver of a privilege. You may revoke this consent through written notice, but it will not apply to action that has been taken prior to receipt of the revocation.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ request and authorize Dr. Ramos

 (Please print full name)

 Receive From Release To Discuss With

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone/Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

the following information from the record of my care and treatment (check all that apply):

* Counseling and/or medical record
* Laboratory/assessment instrument
* Conversations as needed to facilitate continuity of care
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The purpose for this disclosure is:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please note that the law prohibits further dissemination or use of these records for other purposes.

I specifically authorize the release of information pertaining to drug and alcohol abuse and/or HIV testing/test results if such is a part of the record. Release or transfer of the specified information to any person or entity not specified herein is prohibited by law.

This authorization will remain in effect while I am under the care of Dr. Ramos unless otherwise specified here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My signature below indicates that I have read and fully understand the terms and conditions of this agreement. I do voluntarily agree to those terms and conditions contained herein.

Signature Date of Birth Today’s Date