AUTHORIZATION TO RELEASE MEDICAL INFORMATION

1. I, _____, hereby authorize the Athletic Orthopedics and Knee Center to disclose the following specific medical information, by mail or fax, to:
   Name: _____
   Address: _____
   _____
   _____

2. Place your initials in the space(s) before the specific information you want released:
   _____ Record of Clinic Visits
   _____ X-Rays
   _____ Statement of Charges and Payments
   _____ Copies of outside reports which have been provided to Athletic Orthopedic and Knee Center by other medical providers (i.e., hospital records, lab tests, reports from consulting doctors)
   _____ All of the above
   _____ Other (Specify) _____

3. Records requested pertain specifically to my medical treatment beginning on _____

4. This information may be used for the specific purposes designated below, (Article 4495b, §5.08(j), Texas Revised Civil Statues, **requires that an authorization for a release of medical records include "the reasons or purposes of the release"**)

5. I understand that my records are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law.

6. I understand that a photocopy of this authorization is valid as the original.

7. I understand that I may revoke this authorization at any time. In the absence of my prior revocation, this authorization will automatically expire in one year.

8. I understand that you will provide this information within fifteen (15) days of this request, and that a fee will be charged in the amount of $25.00 for the first 20 pages, and .50 for each additional page along with the cost of postage, payable in advance. If X-Rays copies on cd are requested there is a $8 fee for the cd.

_____	_____	_____
Signature of Patient (Or Guardian, if minor)	Date	Date of Birth (For identification Purposes)