DAWN SHOGREN, M.D., P.A.
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DALLAS, TEXAS 75254
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AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____ Date of Birth: _____

I hereby authorize: _____
Individual releasing information

_____ _____
Phone number **Fax number**

_____
Street/P. O. Box

_____
City/State/Zip Code

To release to: _____
Facility/Organization

_____
Street/P.O. Box

_____
City/State/Zip Code

_____ _____
Phone Number **Fax Number**

The following information:

___ **History and Physical** ___ **Lab Results** ___ **MD Progress Notes**
___ **Discharge Summary** ___ **Doctor's Orders** ___ **Nurse's Notes**
___ **Psychological Report** ___ **Initial Psychiatric Exam** ___ **Treatment Plan**

___ **Other:** _____

For the purpose of: _____

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent shall expire sixty (60) days after the patient discharge unless another date is specified, or other longer period is needed for payment of claim and the after fulfillment of legal and/or contractual agreement with any third party payor.

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

To the Party Receiving this Information

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making further disclosure of it without specific written consent of the person to whom it pertains, or otherwise permitted by regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW (42 CFR PART2).

Signature of Patient: _____ **Date:** _____