

Willowbend Health & Wellness Associates

Dr. Phyllis Gee, M.D., P.A. Natalie Settele, P.A.C.

MEDICAL RECORDS AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

By State Law you must be advised that:

The information you authorized for release may include information that should be considered information about communicable diseases, which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome ("AIDS")

Patient Name:	Date of Birth:
Social Security Number:	Treatment Date:

I hereby authorize:

Dr. Phyllis J. Gee M.D.
 4601 Old Shepard Place
 Bldg 2, Suite 201
 Plano, Texas 75093
 Phone (469)361-4000 Fax (469)361-4001

to release all the following health record (s) information of the above name patient, covering the period(s) indicated for the following purpose:

- Insurance Payment Transfer of Care My Doctor's Use
 Referral Care Other _____

The information to be release:

- Pap Smear/Biopsy Results Lab/Pathology AIDS/HIV Test Results
 Operative Report(s) Radiology Reports Bone Density Report(s)
 Prenatal Records Consultations All Records
 History & Physical Exam Mammogram Report(s) Other _____

This information is to be release to:

Name: _____ Organization : _____

Address: _____

Telephone: _____ Fax: _____

I understand this consent can be revoked at any time except that disclosure made in good faith has already occurred in reliance on this consent. Without prior revocation this authorization will automatically expire one year from this date. If the copies of the records are not retrieved within 60 days they will be shredded

I am also informed that health records will be released to the person(s) or organization(s) named above, to those persons or organizations I have other releases granted and to persons or organizations authorized by law.

Patient Signature	Date	Witness Signature	Date
Person Authorized to Sign for Patient		Relationship to Patient	