

**AUTHORIZATION FOR RELEASE OF INFORMATION  
THIS REQUEST MUST BE FILLED OUT COMPLETELY**

**Patient's Name:** \_\_\_\_\_ **SS#** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Address:** \_\_\_\_\_

I authorize \_\_\_\_\_ to disclose my individually identifiable health information as described below, which may include information concerning communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness (except for psychotherapy notes), chemical or alcohol dependency, laboratory test results, medical history, treatment or any other such related information. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by the federal and state privacy regulations. I understand that my health care and the payment of my health care will not be affected if I do not sign this form.

**Information to be released FROM:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**TO: Dr. Joanna Wilson  
Ashley Quillin, FNP-C  
Amarillo Diagnostic Clinic  
6700 W. 9<sup>th</sup>  
Amarillo, TX 79106-1701  
(806) 358-0200  
(806) 468-0784 (Fax)**

**Information to be released: (Check all that apply)**

**History/Physical Exam Notes**  
 **Laboratory Results**  
 **X-Ray Reports**

**Diagnostic Reports**  
 **Other (Please specify)**  
\_\_\_\_\_  
\_\_\_\_\_

**Reason or Purpose for Release: (Check the appropriate category)**

**Continued Patient Care**  
 **Insurance Claim/Application**  
 **Attorney/Legal**

**Personal Use**  
 **Disability Determination**  
 **Other (Specify) \_\_\_\_\_**

I understand that the information released is for specific purpose stated above. Any other use of this information without written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 180 days after the date of my signature unless otherwise specified.

\_\_\_\_\_  
**Signature of Patient or Legal Representative**

\_\_\_\_\_  
**Date**