

Maurice Gagnon, MD
 Joseph Kilianski, Jr., MD
 Thomas Vaughan, Jr., MD
 Brian Welsh, MD
 Michael White, MD

Fax completed form to -
 817-745-2601

Release of Information
 Request



Patient's Name _____		Maiden/Former Name: _____	
Patient's Address: _____			
City, State, Zip: _____			
Birth Date: _____		Social Security #: _____	
Home Phone: _____		Other Phone: _____	
I, Authorize: _____		To Release to: _____	
_____		_____	
_____		_____	
_____		_____	
The following information may be released:		Purpose of Disclosure:	
Entire Medical Record		Medical Care	
Specific Record From _____ to _____		Insurance	
Immunizations		Attorney	
Billing Record		Other _____	
Only			
		I consent to the release of the indicated sensitive, legally protected records (patient to initial). Mental Health Records..... _____ HIV or AIDS _____ Chemical Dependency..... _____ Genetic Testing..... _____	
I understand that I may revoke this consent at any time by notifying the providing organization in writing, except to the extent that action has already been taken in reliance on it and that in any event this consent expires automatically in 180 days from the date of authorization.			
I understand that the information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.			
Signature of Patient or Representative: _____		Date: _____	
Printed Name: _____		Relationship to Patient: _____	
<i>I understand that Chemical Dependency client's/patient's records are protected by the Federal Law (42FR Part2) and cannot be disclosed without this written consent unless otherwise protected.</i>			