E David Pampe, MD
6012 West William Cannon Dr
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Phone : (512) 892-6441
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Authorization for Release of Patient Information

Patient Name : ____ Date of Birth: __ __ / __ __ / __ __ __ __

Address : ____

City : ____ State: _______ Zip Code : _____________

Telephone Number : Cell, Work, and/or Home :____

Send Medical Records To : (Be sure to complete this section to prevent delays in sending your records)

Name of Doctor / Organization : ____

Address : ____

City : ____ State: _______ Zip Code : _____________

Phone : (__ __ __) __ __ __ - __ __ __ __ Fax : (__ __ __) __ __ __ - __ __ __ __

Description of information to be released : (Please check all that apply)

__ Entire Record __ Immunizations __ Laboratory Reports __ Imaging Reports __ Consultation __ Progress Notes

__ Most recent history and physical **Dates of Service**: ____

I understand that the information in my health record may include disclosure of information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol / drug (substance) abuse or any such related information.

This above information is to be disclosed from : E David Pampe, MD (office info above)

Description or the purpose of the use and / or disclosure :

__ Continuing care __ Second Opinion __ Social Security / Disability __ Personal Use __ Insurance
__ Consultation / Referral __ Legal Purposes __ Other: ____

I understand that this authorization is voluntary and I may refuse to sign this authorization, I further understand that my health care and the payment of services rendered will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed. I understand that information used or disclosed pursuant to the authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until __ __ / __ __ / __ __ __ __ (date of event).

I understand that I may revoke this authorization at any time by notifying E David Pampe, MD. I understand that if I revoke this authorization, I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature : ____ Date: __ __ / __ __ / __ __ __ __