BROWDER  **CLINIC, PLLC**

7005 WOODWAY DRIVE, SUITE 201, WACO, TEXAS 76712 254.732.3633

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

_____ _____
Patient Name Date of Birth

_____
Social Security Number

I request and authorize _____ to release healthcare information of the patient named above to:

BROWDER CLINIC, PLLC
7005 WOODWAY DRIVE
SUITE 201
WACO, TEXAS 76712
PHONE: 254-732-3633
FAX: 254-732-3661

This request and authorization applies to:

_X_ All healthcare information

___ Healthcare information relating to the following treatment, condition, or dates _____

_____

_X_ I authorize the release of any records relating to HIV/AIDS, STD, alcohol, or mental health treatment

___ Other: _____

_X_ Purpose is for Continuation of Care

_X_ I am not required to sign this authorization to obtain treatment at Browder Clinic

_X_ If the recipient of this information is not a covered under federal or state privacy law, the information may be subject to redisclosure by the recipient

_X_ I may revoke this authorization in writing at any time except to the extent that Browder Clinic has already relied on this authorization. To revoke my authorization I will provide a written request to the Browder Clinic.

_____ _____
Patient or Legally Authorized Representative Signature Date of Signature