NAVIGATION MEDICAL CENTER
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, ____, with Date of Birth ______________________ hereby authorize NAVIGATION MEDICAL CENTER to disclose the following specific medical information, by mail or FAX to:

Name of Doctor, Facility or Company, Person:____

Address, Phone and Fax:____

Check in the space(s) before the specific wanted information released
____ Copies of outside reports which have been provided by other medical providers (i.e. hospital records, lab tests, reports from consulting doctors).
____ Statement of charges and payments
____ Records of clinic visits
____ All of the above
____ Other (Specify) ______________________________________

Records requested pertain specifically to my medical treatment beginning on ________________, 20_____. This information may be used for the specific purposes designated below:
Article 4495b. §5.08(j), Texas Revised Civil Statues requires that an authorization for a release of medical records include the reasons or purposes of the release"
____ Second opinion by another physician, Dr.____
____ Doctor's Request
____ Insurance Company
____ Disability determination
____ Attorney ___________________________.
____ Other (Specify) ______________________.

4. I understand that my records are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law.
5. I understand that a photocopy of this authorization is valid as the original.
6. I understand that I may revoke this authorization at any time. In the absence of my prior revocation, this authorization will automatically expire in one year.

_______________ _______________________________________
Date Social Security or Driver's License (ID purposes)

_______________________________ ________________________
Signature of Patient (Guardian, if minor) Witness