AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I request and authorize: _____
to release the medical records of the following patients to:

Kathleen E. Ethridge, M.D.
515 N. King Street #101
Seguin, TX 78155

Name of Patient _____ Date of Birth _____

_____ Date of Birth _____

_____ Date of Birth _____

_____ Date of Birth _____

This request and authorization applies to:

_____ All health care information

_____ Health care information related to the following treatment, conditions or dates of treatment:

_____

_____

I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV, AIDS virus, sexually transmitted diseases, psychiatric disorders/mental health and drug and/or alcohol abuse. If I have been tested, diagnosed and/or treated for HIV, AIDS virus, sexually transmitted disease, psychiatric disorders/mental health and drug and/or alcohol abuse you are specifically authorized to release all health care information relating to such testing, diagnosis and/or treatment.

_____ _____
Signature of patient/parent/guardian Date

_____
Printed name of patient/parent/guardian

_____
Relationship to patient

Incoming
Records