Authorization to Release Patient Information

Patient's Name: _____

Date of Birth: _____

Social Security #: _____

This is to authorize the following person(s):

⇨ _____

⇨ _____

⇨ _____

Access to my personal information as shown below:

_____ Billing record

_____ To discuss my medical condition with my provider

This authorization will remain in effect until written notification from my self is received by the Port Lavaca Clinic.

_____ _____

Signature Date