AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of information from the medical record of:

Patient Name: _____ Date of Birth: _____

Social Security # _____ Daytime Phone: _____

INFORMATION RELEASED TO:	FROM:
J. Morgan Lloyd III, M.D.	
7580 Fannin Suite 305	
Houston, TX 77054	
Office #: 713-795-5565	
Fax #: 713-795-5986	

Please Release the Following:

_____ Problem List	_____ X-Ray Reports
_____ Progress Notes	_____ Other Diagnostic Reports (specify)
_____ Lab Reports	_____ Pap Reports
_____ HIV/AIDS	

Purpose or Need for Disclosure:

_____ Continued Patient Care	_____ Personal Use
_____ Attorney/Legal	_____ Insurance Claim/Application
_____ Disability Determination	_____ Other (specify)

I understand that the information released is for the specific purpose state above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless other specified.

_____ _____

SIGNATURE OF PATIENT OF LEGAL REPRESENTATIVE DATE

_____ _____

RELATIONSHIP TO PATIENT WITNESS

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries may in my medical record to prevent my misunderstanding of the information contained in these entries.

I will not hold _____ liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____

SIGNATURE OF PATIENT OF LEGAL REPRESENTATIVE DATE

_____ _____

RELATIONSHIP TO PATIENT WITNESS