AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Name: _____ Date of Birth: _____

Please Obtain Information From/Send To:

_____
Name of Provider/Clinic/Organization

_____
Street/Mailing Address

_____
City, State, Zip Code

Phone:_____Fax:_____

Please Send Information From/To:

Sol Medicine
John Haest, MD

3010 Bee Caves Rd. Ste. 202
Austin, Texas 78746

Phone: (512) 279-2133 Fax: (512) 472-9898
Email: solmedicine@gmail.com

I authorize the following information to be disclosed:

___Treatment Plan ___Mammogram ___Pap
___Previous Orders ___Breast Exam Report ___Pelvic Exam Report

___History & Physical ___EKG ___Last visit Dictation
___Labs/Diagnostic Tests ___Discharge summary

___Other (Specify)_____

For dates of treatment _____ to _____ or Most recent

Reason for Disclosure of Health Information:
____Continued Patient Care

____Other (Specify)_____

Additional Patient Information:

*I understand that I do not have to sign this authorization to get treatment.

*I understand that once my health care information is disclosed as I have authorized, it could be re-disclosed by the recipient and is not longer protected by Sol Medicine.

_____
Patient Signature (Parent or Legal Representative, if applicable)

_____
Date