CLINE FAMILY MEDICINE
MARK A. CLINE, MD
630 HURST STREET
CENTER, TEXAS 75935
PHONE: 936-657-1944
FAX: 936-559-8773

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name: ____________________________ DOB: _____________________ Phone#_______________________

PLEASE OBTAIN INFORMATION FROM:	PLEASE SEND INFORMATION TO:
________________________________	**CLINE FAMILY MEDICINE**
Name of Provider/Clinic/Organization	Name of Provider/Clinic/Organization
________________________________	**630 HURST STREET**
Street Address	Street Address
________________________________	**CENTER, TX 75935**
City, State, Zip Code	City, State, Zip Code
Phone#_____________ Fax#______________	Phone# 936-657-1944 Fax# 936-559-8773

I AUTHORIZE the following information to be disclosed: (please initial all that apply)

_____ Entire Record	_____HIV Record	_____Billing Records
_____Immunization Records	_____STD Record	_____Other
_____Lab Test	_____Psychiatric/Mental Health	
_____TB Test	_____Alcohol/Substance Use	

REASON for disclosure of health information: (please initial)

_____At my request	_____Job	_____Other
_____Continuing	_____School	
_____Legal	_____Insurance	

EXPIRATION of this Authorization: (please initial)

_____ 90 days after signature date___________ on this date_______________________________

_____When this event happens: ____

ADDITIONAL PAYMENT INFORMATION:

- I understand that I have the right to withdraw this authorization. To withdraw, please sign below +
- I understand that I do not have to sign this authorization to get treatment
- I understand that signing this authorization does not cancel any rights I have under other state or federal laws

____ Date: ________________________

Client Signature (Parent or Legal Representative, if applicable) Relationship/Authority

+ I wish to withdraw this authorization: ______________________________________Date:________________________