Consent to Share Medical Information Authorization

Patient Name (please print): _____

Date of Birth: _____ Daytime Phone: (___) _____

Information to be released TO:

Name: _____ Relationship to patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____

Reason for the request: _____

Information to be released FROM:

W Brad Gates, MD, PA
3108 Midway Rd, Suite 105
Plano, TX 75093
Phone: (972) 801-9100 Fax: (972) 378-4846

Please release the following (check all appropriate):

All records	_____	Including Information about:	
Progress notes	_____	HIV / AIDS	_____
Lab results	_____	Drug/alcohol use	_____
Immunizations	_____	Mental Health	_____
Other:	_____	Communicable disease	_____

I understand that I may revoke this consent in writing at any time except to the extent action has already been taken. The information released is for the specific purpose stated above. I understand I will be responsible for any charges occurred based on this request.

_____

Patient Signature (Guardian for patients under 18 years of age) Date

_____

Relationship to the patient