AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize _____to release to:

Triangle Area Network
1495 North 7th Street
Beaumont, TX 77702
Fax: 877-547-8271

Triangle Area Network Orange
3737 N 16th St
Orange, TX 77632
Fax: 888-910-2061

The information of the medical records on:

Patient
Name_____SS#_____

Admit/Treatment Date: _____Birthdate:_____

I hereby authorize the release of the following information, including, if applicable, any treatment or test results for alcohol and/or drug abuse, or reportable communicable diseases, including acquired immune deficiency syndrome or human immuno-deficiency virus infection.

__Inpatient data:_____

__Outpatient data: _____

__Emergency report: _____

The above information is released/requested for medical assessment only purpose, and that purpose only. Any other use is forbidden.

I also understand that I may revoke, in writing, this authorization at any time but not retroactive to the release of information made in good faith.

This authorization will expire one year from the date of my signature.

Patient
Signature:_____Date:_____