AUTHORIZATION FOR RELEASE OF INFORMATION

I herby authorize ____
____
____
____

To release to **KATHRYN A. WAGNER, M.D., P.A.**

414 Navarro, Ste. 1407
San Antonio, Texas 78205
Office (210) 277-6255 Fax (210) 277-6256

Information contained in the medical record of

____
(Name of Patient)

____
(Other name used previously)

____
(Other name used previously)

____
(Social Security Number)

____
(Date of Birth)

Specific information to be released

[] Entire Record
[] Lab/Mammogram and Ultrasound Reports
[] Clinical Notes
[] Operative Report (Date :____________)
[] Pathology Report
[] Other: ________________________________

Dates of Service: ____

I give permission for release of any information in my record, including information relevant to substance abuse, psychiatric/mental health services or HIV information, unless specifically excluded as noted below:

Do not release information related to:

[] HIV
[] Substance Abuse
[] Psychiatric/mental health services
[] Other________________________

I also understand that I may revoke the authorization at any time except to the extent that action has been taken in reliance on it and that in any event this authorization automatically expires 90 days from the date of my signature or as otherwise specified by date, event, or condition as follows:

____

____

____ _________________

Signature of Patient or Legal Representative Date