Aaron L. Cernero D.O., P.A.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

5012 SOUTH US HIGHTWAY 75, STE 205
DENISON, TX. 75020
PHONE (903) 462-4247 FAX (888) 212-0812

Patient Name _____ Date Of Birth _____
Phone Number _____ Last 4 Of SSN _____

Above listed patient authorizes Aaron L. Cernero D.O., P.A. to make records disclosure to and receive records from the following healthcare providers or facilities:

PLEASE LIST ANY DOCTORS YOU'VE SEEN IN THE LAST 5 YEARS:

Physician Name (First & Last)/ Specialty	Phone Number	Fax Number
Physician Name (First & Last)/ Specialty	Phone Number	Fax Number
Physician Name (First & Last)/ Specialty	Phone Number	Fax Number
Physician Name (First & Last)/ Specialty	Phone Number	Fax Number
Physician Name (First & Last)/ Specialty	Phone Number	Fax Number

DATES AND TYPE OF INFORMATION TO DISCLOSE:

- Please send 1 visit note with the patient's **HEIGHT** and **WEIGHT** from **each year that the patient was seen in your office**, or **for the past 5 years**
- Entire medical record for the past 2 years
- Entire medical record for the past 5 years
- Specific Information Requested:_____

THE PURPOSE OF DISCLOSURE:

- Medical Care
- Consideration For Surgery

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

_____ I authorize this information to be disclosed to/from Aaron L. Cernero D.O., P.A.

_____ I do not authorize this information to be disclosed to/from Aaron L. Cernero D.O., P.A.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
This authorization will expire on the date:_____. If no expiration date is specified, this authorization will expire 1 year from the date signed.

Signature of Patient/Parent/Guardian or Authorized Representative Date

Printed Name of Authorized Representative Relationship to Patient