Michael E. Buxbaum D.O.
6699 Chimney Rock Suite 201
Houston, Texas 77081

Phone (713) 533-1700
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

_____ (Name of Physician or Hospital)

Patient Name and Address: _____

Social Security No: _____

Birth Date: _____

I, the undersigned, authorize _____ (Name of Physician or Hospital)

to furnish medical information concerning the above-named patient to the following persons and institutions:

Dr. Michael E. Buxbaum
6699 Chimney Rock Suite 201
Houston, TX 77081

This medical information is to be the entire record unless specified by the following:

_ Discharge Summary _ Operative Report _ EMG Report _ Consultation _ Pathology Report _ EKG Report _ X-ray Film_ Emergency Room Report _ X-ray Report _ History & Physical _ _ Laboratory Report _ Birth/Delivery Records_Other_____

The above-named persons and institutions may use the information authorized only for the following purposes: _ Continuing Care _ Insurance _ Attorney _ Personal Use
Other_____

The further use or disclosure of the authorized information by the above-named persons and institutions may not be accomplished without my further written consent.

This authorization shall become effective immediately and shall be valid until _____.
If I do not specify any expiration date, event or condition, this authorization will expire in six months from the date of my signature or upon satisfaction of the need for disclosure.

Statement of Authorization:
I do not authorize further release to any third party. I understand that once the information is released as specified in this authorization, the facility, their employees and my physician(s) cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.
· I consider a photocopy of this authorization to be as valid as the original. I understand that I may upon request inspect the information to be disclosed.

_____ _____

Signature of Patient/ Legally Authorized Representative Date

_____
Relationship to Patient