AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

I, _____, hereby request and authorize

PrimeCare Medical Group
929 Gessner, Suite 2450
Houston, TX 77024
Ph: (713) 464-9939
F: (713) 464-9942

to release a copy of my medical records to:

Physician or Hospital name:_____

Address:_____

City:_____ State:_____ Zip code:_____

Phone:_____ Fax:_____

This authorization applies to all the reports checked:

_____ History and Physical
_____ Progress Notes
_____ Electrocardiogram (EKG)
_____ Lab Work
_____ Pulmonary Function Test
_____ Physical Examination
_____ Diet History Records
_____ Out-Patient Testing Radiological Studies
_____ **All Records**

The purpose of this disclosure is for Medical care. This authorization is valid for 90 days from the date of signature by the participant.

Prohibition of redisclosure - Federal rules prohibit any further disclosure of this information unless disclosure is expressly permitted by written consent of the person to whom it pertains.

Patient signature:_____ Date:_____

Printed Name:_____ Date of Birth:_____

Social Security Number:_____

Witness:_____ Date:_____