BRADLEY AXLINE, MD

WELLNESS FOR WOMEN & MEN

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

I authorize _____ to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below by mail.

Please send my protected health information to:

Bradley Axline, MD

2560 Central Park Ave Suite 340

Flower Mound, TX 75028

PH: (972) 538-2100 Fax: (972) 539-2231

Please check which records are needed:

□ Discharge Summary	□ Laboratory Test
□ History & Physical	□ Radiology Reports
□ Progress Notes	□ Pathology Reports
□ OP Report	□ other (slides, films)
□ Emergency Record	□ All Records

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon authorization. Information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected. I understand that treatment or payment cannot be conditioned on my signing this authorization except in certain circumstances such as for participation in research programs or authorization of the release of testing for pre-employment purposes.

Signature of Patient: _____ Date: _____