Consent for Medical Release

I, _____, DOB_____, Social Security_____
hereby request and authorize that my medical records be released to:

Willy Pezzia, M.D., P.A.
And Associates
714 S. Peek Road
Katy, Texas 77450-3181
O: 281-395-3955 F: 281-395-3959

From: _____

_____

_____

O: _____F:_____

To release the complete medical records in your possession concerning my illness and or/treatment during the periods of care from _____ to _____.

This authorization applies to all of the reports checked:

____ Copy of complete health records ____ History and Physical
____ excluding information related to HIV testing and/or results
____ Other _____

PLEASE FAX RECORDS TO OUR SECURA HIPPA FAX: 281-395-3959
IF MORE THAN 15 PAGES PLEASE MAIL TO ABOVE ADDRESS

I understand this consent can be **REVOKED** at any time except to the extent that disclosure made in good faith has already occurred in reliance on this account.

Specification of the date, event or condition upon which this consent expires, _____, or expires one year from the date signed.

The facility, its employee's and officers and attending physician, or physician assistants are released from legal responsibility or liability for the release of the above information to then extend indicated and authorized herein.

Signed _____ _____
Patient or Representative Date of Birth

_____ _____
Witness Date Signed