SETMA I - 2929 Calder, Suite 100
SETMA II - 3570 College, Suite 200
SETMA West - 2010 Dowlen
(409) 833-9797
www.setma.com

Southeast Texas Medical Associates, LLP
AUTHORIZATION TO RELEASE/OBTAIN MEDICAL RECORDS

I, _____who resides at _____ in the city of _____in the state of ____ hereby authorize:

Name: _____

Address: _____

City, State,Zip: _____

To disclose the following specific information by _____ mail or ____ fax to:

Mail Recipient: Southeast Texas Medical Associates, LLP

Address: 2929 Calder Ste 100

City, State,Zip: Beaumont, Texas 77702
Fax: 409-654-6906

For the purpose of _____.
My authorization extends only to those data elements/documents ***initialed*** below:

_____ All of the below
_____ Statements of charges or payments
_____ Records of visits (all visits)
_____ Record of a visit for a specific date or dates. Specific dates are limited to _____
_____ Copies of records provided to the above named (i. e. hospital, lab, clinic, etc.)
_____ Progress notes
_____ Photographs, videotapes, digital or other images
_____ Discharge summaries
_____ History and physical examination
_____ Consultant reports
_____ Mental health and/or alcohol abuse treatment
_____ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) information
_____ Hepatitis information
_____ Other (must be specific) _____

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

2. A photocopy or fax of this authorization is as valid as the original.

3. I may revoke the authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.

4. Southeast Texas Medical Associates, LLP, its employers, its officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

5. Treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining this authorization.

6. Information used or disclosed pursuant to this authorization may be subjected to re-disclosure by the recipient and is no longer protected.

_____ _____

PATIENT NAME, PRINTED DATE

_____ _____

PATIENT'S SIGNATURE (OR GUARDIAN, IF MINOR) ABOVE) EXPIRATION DATE (IF OTHER THAN ONE YEAR FROM DATE

_____ _____

SOCIAL SECURITY NUMBER (FOR ID PURPOSES ONLY) DATE OF BIRTH

_____ _____

PATIENT'S PERSONAL REPRESENTATIVE DATE

_____

PATIENT'S PERSONAL REPRESENTATIVE AUTHORITY TO ACT

_____

WITNESS