AUTHORIZATION TO OBTAIN HEALTH CARE INFORMATION

I hereby authorize **Alexandra Pellicena, MD, PA** located at 1919 North Loop West, Suite 215, Houston, TX 77008, to request a copy of my medical record, including any HIV test results for the following period:

All Records or Records from _____to _____

From: _____
Doctor's Name

_____
Street Address

_____
City, State, Zip Code

_____
Phone/Fax Number

This authorization is valid for 90 days from the date of signature by the patient.
Federal rules prohibit any further disclosure of this information unless disclosure is expressly permitted by written consent of the person to whom it pertains. This authorization releases you, your physicians and employees from liability for following this authorization request.

Signature of Patient Date

Patient's Printed Name Date of Birth Patient Account #

Patient's Address, City, State, Zip Code

Witness Signature Date