Lone Star Infusion PLLC

Authorization for Release of Information

Patient Name _____ Date of Birth _____

Entity Releasing Information:

Physician or Practice Name _____ Physician or Practice Phone _____

Physician or Practice Email _____ Physician or Practice Fax _____

The above-named patient authorizes health information to be released to Lone Star Infusion, PLLC.

Please provide treatment records and other relevant documentation to:

Mail: Lone Star Infusion, PLLC
10505 Town and Country Way #79809
Houston, TX 77279

Fax: 281-719-9393

Authorization for Release of Information:

I hereby authorize above named Entity Releasing Information to release any information necessary regarding the patient to Lone Star Infusion, PLLC including, but not limited to, patient health information.

I hereby authorize Lone Star Infusion, PLLC to obtain from any source and examine and use, or discuss and disclose and provide any information necessary regarding the patient with insurance companies and with health care practitioners involved in the care of the patient. These communications of information may include unencrypted electronic communications.

This authorization to obtain and release information is valid until revoked. The undersigned may revoke this consent in writing at any time, except with regard to information that has already been shared or disclosures that have already been made in reliance on such consent.

_____ _____

Signature of Patient or Patient Representative Date