GREG KRENEK, M.D.

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Name _____Date of Birth_____

I request and authorize _____
Name of Clinic/Physician

Address:_____

City:_____State:_____Zip:_____

To release the medical records of the patient named above to:

Greg Krenek, M.D.
503 Medical Center Blvd., Suite 140
Conroe, TX 77304
(936) 756-0668 Office (936) 756-7787 Fax

This request and authorization applies to:

_____Health care information relating to the following treatment, condition or dates of treatment

_____

_____All health care information

_____Other_____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV(AIDS virus), sexually transmitted disease, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV(AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

_____ _____
Signature of Patient Date

_____ _____
Witness Date

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED.