

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize \_\_\_\_\_ to  
release to:

**Triangle Area Network**  
**1495 North 7<sup>th</sup> Street**  
**Beaumont, TX 77702**  
**Fax: 877-547-8271**

**Triangle Area Network Orange**  
**3737 N 16<sup>th</sup> St**  
**Orange, TX 77632**  
**Fax: 888-910-2061**

The information of the medical records on:

Patient  
Name \_\_\_\_\_ SS# \_\_\_\_\_

Admit/Treatment Date: \_\_\_\_\_ Birthdate: \_\_\_\_\_

I hereby authorize the release of the following information, including, if applicable, any treatment or test results for alcohol and/or drug abuse, or reportable communicable diseases, including acquired immune deficiency syndrome or human immuno-deficiency virus infection.

\_\_\_ Inpatient data: \_\_\_\_\_

\_\_\_ Outpatient data: \_\_\_\_\_

\_\_\_ Emergency report: \_\_\_\_\_

The above information is released/requested for medical assessment only purpose, and that purpose only. Any other use is forbidden.

I also understand that I may revoke, in writing, this authorization at any time but not retroactive to the release of information made in good faith.

This authorization will expire one year from the date of my signature.

Patient  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_