Records should be sent to:
MICHAEL C. SPECK, M.D.
1892 W. US HWY 290
FREDERICKSBURG, TX 78624
P: 830-304-1666
F: 830-304-1665

Authorization for Release of Health Information

Patient Name: _____
Date of Birth: _____
Address: _____

This authorization applies to the following information: (please check one)

_____ALL information. I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, AIDS/HIV information, and/or other sensitive health information.
_____ONLY the following records or types of information may be released.

Treatment Dates: FROM _____/_____/_____ to _____/_____/_____

The information may be released as follows: (please provide address and phone number)
FROM: (Person/Organization)

_____
ADDRESS and PHONE NUMBER

_____
TO: (Person/Organization)

_____
ADDRESS and PHONE NUMBER

_____

Purpose of Release:
Continuity of Treatment_____ Other (specific reason)_____

I understand the information released will be limited to information needed to fulfill the need of the disclosure. This authorization is valid for ninety (90) days from the date of signature. I understand I may revoke this authorization in writing at any time by completing a form. If I revoke this authorization, the revocation will not apply to information that has already been released in response to this authorization. Before requesting medical record copies, please ask about the copy fee that may apply. I represent that I have the authority to and voluntarily grant permission for the information to be released as described above.

_____ _____ _____
PARENT/LEGAL Guardian Printed Name PARENT/LEGAL Guardian Signature DATE

_____ _____ _____
Patient Signature if 14 or older Witness Signature DATE