Christina Sebestyen, M.D., P.A. 12221 Renfert Way, Suite 330 Austin, TX 78758 512-425-3825 Phone 512-425-3829 Fax

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

We are unable to process incomplete forms. Please complete all areas.

Records Requested:	
	ate the area below if HIV/AIDS test results is to be included.
Records of care from(date) to Other (please specify)	(date) only.
Confer with another person orally about inform	nation in my record. Specify person under "To"
acquired immunodeficiency syndrome (AIDS), or hu	y include information relating to sexually transmitted disease, man immunodeficiency virus (HIV). It may also include es and treatment for alcohol and drug abuse. Please initial your
Yes, I consent to the release of this information	No, I do not consent to the release of this information.
Reason for Release:	
Change of physician	Disability Claim
Patient moving	Other:
Consultation with another physician	Please tell us why you are transferring:
FROM: (Need complete Name, Address, Phone)	TO: (Need complete Name, Address, Phone)
Name	Name
Address	Address
City, State, Zip	City, State, Zip
Phone Fax	Phone Fax
understand I have the right to revoke this authorization must do so in writing and present my written revocation revocation will apply to my insurance company where under my policy. Unless otherwise specified, this aution I understand a reasonable amount of time, not to exceed the same that the same transfer is the same transfer in the same transfer in the same transfer is the same transfer in the same transfer in the same transfer is the same transfer in the same transfer in the same transfer is the same transfer in the same tr	f information described above from my medical record. I on at any time. I understand that if I revoke this authorization, I ion to Christina Sebestyen, M.D., P.A. I understand the n the law provides my insurer with the right to contest a claim thorization will expire in six (6) months. eed 15 days, may be required to retrieve my records. A fee may mum fee will be \$25.00. This request will be processed once
Signature of patient or legal representative (If not patient, state relationship to patient and reason patient unable to sign.)	Date Signed
Patient's full name (Please print)	Social Security Number Date of Birth