Dr. Paul W. John, M.D., P.A.
11671 Jollyville Rd., Suite 202
Austin, TX 78759
Phone 512-343-9848
Fax 512-346-6492

I authorize :_____(previous physician)

_____
Address phone# fax#

To release information from the medical record of:

_____ _____/ _____/ _____ _____
Patient Name Birthday Social Security#

To: Paul W. John, M.D., P.A.
11671 Jollyville Rd, Suite 202
Austin, TX 78757
Phone 512-343-9848
Fax 512-346-6492
Dates Requested: All

Purpose for release of information; Continuation of Medical Care

Information to be released:

Reports may include information on drug/alcohol/psychological/HIV or communicable disease treatment.

Consultation Notes___	Immunizations___
History and Physical___	EKG'S ___
Progress Notes___	Radiology Reports___
Laboratory Reports___	HIV/AIDS___

Other_____

I understand that I may revoke this consent at any time except to the extent that action has already been made before receipt of revocation. This authorization expires automatically one hundred eighty (180) days from the date of signature or as otherwise specified. I understand that I may be charged for copies of my medical records. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. Paul W. John, M.D., P.A., will not be responsible for any discrimination or disclosure of your confidential information once we provide such information, at your request, to your health insurer, employer, attorney or other designee. I agree that a photocopy of this authorization may be considered valid.

Signature of Patient_____Date_____

Signature of Parent/Legal Representative_____Date _____