LAS COLINAS OBSTETRICS-INFERTILITY ASSOCIATION, P.A.
3501 N. MacArthur, Suite 350
IRVING, TX 75062
Office: (972) 257-5300 **Fax: (972) 257-5322**

I, _____, give permission to Dr. John J. Zavaleta, M.D. or any of associates / staff, to release any information regarding my medical history or billing records to anyone listed below _____.

_____ _____
Patient Signature Date

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed the offices' Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed Name of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority