LAS COLINAS OBSTETRICS-GYNECOLOGY-INFERTILITY ASSOCIATION, P.A.
3501 N. MacARTHUR, SUITE 350
IRVING, TX 75062
OFFICE : (972) 257-5300 FAX : (972) 257-5322

I,_____, give permission to John J. Zavaleta, M.D., or any of his associates / staff, to release any information Regarding my medical records or billing records to _____.

_____ _____
Patient Signature Date

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's 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

_____
Signature of Patient or Personal Representative

_____
Description of Personal Representative's Authority