NAVIGATION MEDICAL CENTER

3003 Navigation Blvd., Houston, TX 77003
Fax: 713-223-1571 Phone: 713-223-4466
Web: www.navigationmedical.com

Jaime E. Duarte MD FAAFP
Sonia P. Moncayo MD
Gina P. Galindo MD
Clarissa L. Barrera PA-C

RECOGNIZED NCQA PATIENT-CENTERED MEDICAL HOME

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____, born in _____ hereby authorize NAVIGATION MEDICAL CENTER to disclose the following specific medical information, by mail or FAX to:

Name of Doctor, Facility or Company, Person:_____

Address, Phone and Fax:_____

Check in the space(s) before the specific wanted information released

____ Copies of outside reports which have been provided by other medical providers (i.e. hospital records, lab tests, reports from consulting doctors).
____ Statement of charges and payments
____ Records of clinic visits
____ All of the above
____ Other (Specify) _____

Records requested pertain specifically to my medical treatment beginning on _____, 20_____. This information may be used for the specific purposes designated below:
Article 4495b. §5.08(j), Texas Revised Civil Statues requires that an authorization for a release of medical records include the reasons or purposes of the release"

____ Second opinion by another physician, Dr. _____
____ Doctor's Request
____ Insurance Company
____ Disability determination
____ Attorney _____.
____ Other (Specify) _____.

4. I understand that my records are confidential and cannot be disclosed without my written authorization, except as otherwise provided by law.
5. I understand that a photocopy of this authorization is valid as the original.
6. I understand that I may revoke this authorization at any time. In the absence of my prior revocation, this authorization will automatically expire in one year.

_____ _____
Date Social Security or Driver's License (ID purposes)

_____ _____
Signature of Patient (Guardian, if minor) Witness