William D. Strinden, M.D. P.A.
Plastic & Reconstructive Surgery
Hand Surgery

PO Box 153720
Lufkin, TX 75915-3720
Facsimile 913-261-9560

Authorization for Release of Information

1. I hereby authorize William D. Strinden, MD to release the following for:

_____
(Patient Name)

_____
(Address)

_____ _____
(SSN) (Date of Birth)

Covering the dates of care from_____ to_____.

2. Information to be released:
   _____Copy of complete health record
   _____Excluding information related to HIV testing/Mental Illness/Drug/Alcohol Abuse
   _____History and Physical
   _____Other_____

3. Information is to be released to:_____

   Address for mailing_____
   Method via US Mail. Send $5.00 to address above. Records mailed after receipt of check.

4. Purpose of disclosure:_____

5. I understand this consent can be REVOKED at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

6. Specification of the date, event or condition upon which this consent expires. _____

7. The facility, its employees and officers and attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Signed:_____ _____ Date:_____
(Patient or representative) (relationship)

_____ Date:_____
(Witness)