Quanita J. Crable, M.D.

AUTHORIZATION TO DISCLOSE OF HEALTH INFORMATION

Name: ______________________________ Date of Birth: ___/___/______

I authorize:
Name: ______________________________
Address: ______________________________
____
Phone: ________________ Fax: ________________

To disclose health information to:
Name: Quanita Crable, MD
Address: 8160 Walnut Hill Lane Ste 210
Dallas, Texas 75231
Phone: (469)364-3764 Fax: (469)364-3766

Please specify the health information you authorize to be released:

Type(s) of health information: ______________________________

Specify date(s) of treatment or time period: ______________________________

Please describe the purpose of this release: ______________________________

____

The following information will not be released unless you specifically authorize it by *initialing* the relevant line(s) below:

_____ I specifically authorize the release of HIV/AIDS test results (Health and Safety Code §120980(g)).
Initial

Expiration of Authorization: Unless otherwise revoked, this Authorization expires on ________________.
If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

Please read the important notice concerning your rights on the following page.

Signature:

______________________	______________________	______________________
Signature (Patient, Parent, Guardian)	Print Name	Date Time
______________________	______________________	______________________
Relationship to Patient (Parent/Guardian/ Conservator/Patient Representative)	Witness (if patient unable to sign) or Interpreter	Phone Number