KILLEEN DIGESTIVE DISEASE CONSULTANTS, PA
XIAOTUAN ZHAO, MD
2301 S. CLEAR CREEK RD STE 102
PHONE: 254-519-8490
FAX: 254-519-8495

Authorization for Release of Information:

I hereby authorize the following information to be released from the medical record of :

Patient Name:___________________________________ Date of Birth:_____________

This information needs to be Released to:

To:____________________________ **From**:__________________________

_______________________________ _______________________________

_______________________________ _______________________________

Progress Notes	MRI Report	Pathology Report
Lab Report	History/Physical	Emergency Rm. Report
X-Ray Report	Operative Report	Other

I understand that to the extent any recipient if this information, as identified above, is not a "covered entity" under Federal of Texas Privacy law, the information may no longer be protected by Federal or Texas law once it is disclosed to the recipient and, therefore, may be subject to re-disclosure by the recipient.

I understand that I may revoke this authorization in writing at anytime except to the extent that the clinic of Dr. Xiaotaun Zhao has already relied on this authorization. I understand that I may revoke this authorization by providing a written request for revocation starting my intent to revoke this authorization.

I understand that Dr.Xiaotaun Zhao may not condition treatment on my completion of this authorization form.

If information that the clinic of Dr. Xiaotaun Zhao is being released directly to me, I understand that my medical record contain reports, test results, and notes that only physicians can interpret. I understand that I have been advised that I should contact my physician regarding the entries made in my medical records to misunderstanding of the information that has been written in the record. I will not hold the clinic of Dr. Xiaotaun Zhao liable for any misinterpretation of the information in my record as a result of not consulting my physician for the correct interpretation.

This authorization will expire in 180 days, or at the date or event specified here:____________

I understand that the information released for the specific purposed stated above and may not be provided in whole or in part to any other agency, organization, or person.

____ ____________________

Signature of Patient or Legal Representative **Date**