Sue M. Palmer, M.D., P.A.
Maternal Fetal Medicine
1200 Binz, Suite 670
Houston, TX 77004

RELEASE OF CONFIDENTIAL INFORMATION CONSENT

_____
Patient Name (Please Print) (First, Middle, Last)

_____
Address City State Zip

_____
Date of Birth Social Security Number Phone Number

(FROM) I hereby freely, voluntary, and without coercion, authorize (Name and address you wish to obtain records from):

Doctor/Hospital _____

_____
Address City/State/Zip Phone Number

(TO) to release a copy of my medical information to :
Sue M. Palmer M.D.,P.A. 1200 Binz, Suite 670 Houston, TX 77004,
Phone: 713-521-2229 Fax: 713-522-3334

MY MEDICAL RECORDS MAY INCLUDE INFORMATION REGARDING TESTING OR DIAGNOSIS AND/OR TREATMENT OF CHEMICAL DEPENDENCY,HIV TESTING, AND/OR HIV TREATMENT FOR ACQUIRED IMMUNE DEFICIENCY SYNDROME(AIDS),PSYCHIATRIC DISORDERS AND/OR DRUG/ALCHOL ABUSE. THE INFORMATION TO BE RELEASED INCLUDES:

DATE(S) OF THE RECORDS NEEDED:_____

CHECK ALL THAT APPLY: ____PERTIENENT INFORMATION FOR CONTINUING CARE, OR

___Discharge note	___Pathology Reports	___Eye Records	___X-ray Reports
___Shot Records	___History & Physical	___Lab Results	___Daily Progress Notes

This consent will expire 180 days from the date signed below. I understand that I may revoke this consent at any time. It must be revoked in writing, addressed and sent to Sue M. Palmer M.D.,P.A..

_____
Patient (or LEGAL GUARDIAN) Signature Date

_____
Witness Signature Date