Loy Graham, MD

Your Personal MD

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, do hereby authorize to release information from the medical record of:

Patient Name:
Date of Birth:

FROM:

TO: **Loy Graham, MD**
Your Personal MD
181 Town Center Blvd. Suite 400
Jarrell, TX 76537-0767
Phone:
Fax:

Information to be released:

- ☐ History & Physical
- ☐ Laboratory
- ☐ EKG
- ☐ X-Rays/Imaging
- ☐ HIV/AIDS
- ☐ Consultation
- ☐ Progress Notes
- ☐ All Medical Records
- ☐ Other:

Reason for Release of Information:

- ☐ Change of Physician
- ☐ Continuity of Care
- ☐ New Patient

Other:

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it and that, in any event, this authorization expires automatically ninety (90) days from the date of signature.

Signature: Date: