David Flume, M.D.
300 Beardsley Ln.
Bldg. C, STE 202
512-329-5575 Ph
512-329-6141 Fx

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient: _____ Ph: _____ D.O.B. _____

Address: _____
Street City/State Zip

I authorize the following release of medical information:

_____

_____

from and/or to: _____

Phone: _____ Fax: _____

Address: _____

to and/or from: _____

Phone: _____ Fax: _____

Address: _____

I understand that such disclosure will be made for the purpose of psychiatric treatment.

_____ _____
Date Signature of patient

_____
Witness

Print Form