RELEASE OF MEDICAL INFORMATION

I hereby authorize : **Gail Blakley M.D.**
c/o Occucare International
5151 Katy Fwy #170
Houston, TX. 77007

Phone: (713) 225-0463
Fax: (713) 802-0105

To release to: _____

Address: _____

Fax: _____ Phone: _____

The Following Information:

_____ My entire medical record
_____ Medical records concerning only:
_____
_____
_____

I give my permission for this medical information to be used for the following purpose only, and I do not give permission for any other use or re-disclosure of this information.

_____ Additional diagnosis and treatment.
_____ Determination of medical clearance for employment.
_____ Other:_____
_____
_____

Name:_____ Date:_____

Soc Sec#_____D.O.B._____

Signature:_____

I am aware that this consent shall remain in effect for 6 months, unless I specify otherwise. I am aware that I may revoke this consent by presenting to the clinic and signing the revocation order below at any time during business hours.

☐ I wish to specify an alternative time frame during which this consent is valid:_____.

☐ I wish to revoke authorization of the release of my medical information as of: _____.

Signature:_____