ALLIANCE HEALTH RESOURCES
MOBILE DIVISION, LTD.

2818 Center Street
Deer Park, Texas 77536
(281) 479-6672

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Employee Name: _____
Last First Middle

DOB: _____ SS#: _____

Street Address: _____

City: _____ State: _____County: _____

Zip Code: _____ Phone: (_____) _____

I, _____,
First Name Middle Name Last Name

hereby authorize **ALLIANCE HEALTH RESOURCES Mobile Division, Ltd.** to release all information obtained during medical surveillance and occupational related encounters to:

_____
_____
_____

Contact Person: _____ Phone: _____

- This authorization shall expire one year after my employment with _____ ceases.
- I may revoke this authorization in writing by contacting your office at the above address.
- I understand that I may periodically be asked to update this Medical Release Form at the discretion of Alliance Health Resources Mobile Division, Ltd.

_____ _____
Patient Signature Date