

Dr. Mark Lobaugh's Office
2111 S. Clear Creek Road
254.519.BABY (2229)
254.519.2231 (FAX)
<http://www.519baby.com>

GENERAL AUTHORIZATION

MEDICAL INFORMATION AUTHORIZATION

TO: Dr. Mark Lobaugh and Staff

RE: _____ (Name of patient)

You are hereby authorized to furnish _____ (Name of person to whom you would like to disclose information) any or all medical information concerning my injuries, disabilities and physical condition, including all medical records and x-rays covering the period from _____, 20__ to _____, 20__. You are directed and authorized to furnish complete medical reports on my medical history, past, present and future and to permit _____ (Name of person to whom you would like to disclose information) to view, copy or obtain photocopies or other such reproductions of any medical record in your possession covering the above period upon his/her request(s). A photostatic copy of this authorization shall be considered as valid as the original.

I understand that if I wish to revoke this agreement during the above time period, I must do so in writing.

Signature

Date

Witness

Date

**Not Valid if Presented to Dr. Mark Lobaugh's Office More than 90 Days
From Date of Authorization**

Not Valid if Dated Prior to Period of Treatment