AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

TO: ____

RE: ____

Social Security # _________________________ Date of Birth _____/______/______

Phone: ( ) - __________________________

Address: ____ as described below to

Andrea M. Zaite, LLC
12430 Golden Thistle
Houston, Texas 77058
281-910-0930
amzaite@gmail.com

Review of the Medical Records in addition to discussion with Providers are requested for the purpose of:

___ Discharge Planning _____ Geriatric Care Management _____ Patient Advocacy

___ Other

I understand that this authorization is effective for a year from the date of the signature below. I understand I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release information. I am entitled to a copy of this completed authorization for. I am not required to sign this form in order to receive services from Andrea M. Zaite, LLC and its staff have no responsibility or liability as a result of this disclosure. I understand if I choose to not sign this form it will limit the ability of Andrea M. Zaite, LLC to be effective in the management of my care.

Signature: ______________________________________ Date: _____________

Relationship: ____________________________________