INTERNATIONAL CRANIOFACIAL INSTITUTE
CLEFT LIP AND PALATE TREATMENT CENTER

CONSENT FOR RELEASE OF INFORMATION

1. I hereby authorize International Craniofacial Institute
   Address: 7777 Forest Lane C717 Dallas TX 75230
   Phone: 972-566-6555 Fax 972-566-6017

   To release the following information from the health records of:

   Patient's name: ____
   Date of Birth: ___________________________SS# ______________________________

   Covering the period(s) of treatment from ___________________ to _________________

2. Information to be released:

   _______ History & Physical
   _______ Billing records
   _______ Operative Reports
   _______ Complete health record
   _______ Other ______________

3. Information is to be released to:

   Name: ____
   Address:____
   City: ___________________________ State: _______ Zip ________________

4. Purpose of Disclosure: ____

5. I understand this consent can be revoked at any time except to the extent that disclosure of information has already occurred prior to receipt of the revocation by this office. If revocation is not received, authorization will be considered valid for a period of time not to exceed one year.

6. Date this consent expires: ____

7. The facility, its employees and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

8. I understand that the information released could contain reference to or results of HIV antibody (AIDS) testing.

SIGNATURE: _________________________________ **DATE**: _________________________

Relation to Patient: _____________________________________

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Dallas, Texas 75230
972.566.6555
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