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 _____ Complete health record
   _____ Billing records
   _____ Operative Reports _____ 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: _____