



LifeNet, Inc.

Patients Name \_\_\_\_\_ Run Number \_\_\_\_\_

Date of Service or Treatment \_\_\_\_\_

**(Authorization good only for service dates above)**

Permission is granted to: LifeNet, Inc.  
6300 Hampton Rd, Texarkana TX 75503

To convey the information contained in my medical record to:  
(requesting hospital, doctor, insurance, etc.) \_\_\_\_\_

\_\_\_\_\_  
Address

I hereby authorize the above named source to release or disclose the following information for the period(s) identified above:

All medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my condition, including psychological or psychiatric impairment, or drug/and or alcohol treatment, HIV/AIDS or sickle cell anemia.

I understand that this consent is subject to revocation by me at any time, except to the extent that action has been taken in reliance with the consent prior to revocation. In any event, this consent will expire ninety (90) days from execution.

\_\_\_\_\_  
Patient Signature Date

If the patient is a minor, deceased, or legally incompetent, a signature of the legally appointed responsible party is necessary below.

\_\_\_\_\_  
Responsible Party Date

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Witness Date