Health & Safety Code, Title 2- Health
Chapter 12, Powers & Duties of the Texas Department of State Health Services

§ 12.096. Physician Report
(a) A physician licensed to practice medicine in this state may inform the Department of Public Safety of the State of Texas or the medical advisory board, orally or in writing, of the name, date of birth, and address of a patient older than 15 years of age whom the physician has diagnosed as having a disorder or disability specified in a rule of the Department of Public Safety of the State of Texas.
(b) The release of information under this section is an exception to the patient-physician privilege requirements imposed under Section 159.002, Occupations Code.

§ 12.098. Liability
A member of the medical advisory board, a member of a panel, a person who makes an examination for or on the recommendation of the medical advisory board, or a physician who reports to the medical advisory board or a panel under Section 12.096 is not liable for a professional opinion, recommendation, or report made under this subchapter.

Patient’s Last Name, First Name, M.I. __________________________________________________________
Patient’s Address: _______________________________________________________________________
Patient’s City, State & Zip: ___________________________________________________________________
Patient’s Date of Birth: ______________________________________________________________________
Patient’s Driver License #, if known: ______________________    Social Security # _____________________
Explain specific medical limitations to driving for this patient:
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
_________________________________________  __________________________________________
Signature of Physician       Printed Name of Physician
_________________________________________  __________________________________________
Texas Physician License Number     Address of Physician
(______)__________________________________  __________________________________________
Telephone Number of Physician     City, State, Zip

www.dshs.state.tx.us/emstraumasytems/mabhome.shtm
FOR YOUR CONVENIENCE, THIS FORM MAY BE Copied

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