MEDICAL ADVISORY BOARD
Texas Department of State Health Services

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
FORM for
Driver License Applicants

I, (Last Name)_________________________ (First Name)__________________________
DL # __________________ authorize the following Health Care Provider: (Individual, Physician,
Hospital, Clinic, Public Health Dept., etc.)

______________________________________________________________________________
______________________________________________________________________________

Address/City/State/Zip
to provide the confidential health and medical information in my clinical records necessary for the
Texas Medical Advisory Board (MAB) to determine my present fitness to exercise sound judgment
with respect to the safe operation of a motor vehicle, as it relates to the driver’s license vehicle class
for which I have applied. Such information should include any information on any conditions that
cause or are likely to cause substantial impairment in the patient’s ability to safely operate a motor
vehicle. This information should be released to the:

The information furnished by the named health care provider to the designated individual and any
reports prepared by the MAB may be released by the individual, or the Texas Department of State
Health Services in the manner and for the purpose permitted in the Health and Safety Code, Chapter
12, Sections 091 - 098, and the rules of the Texas Board of State Health Services adopted pursuant to
the above stated law to govern the activities of the MAB.

I understand I am to pay any professional fees connected with this examination.

This authorization to the Medical Advisory Board and the Texas Department of State Health Services
is effective until the receipt by the department of a written withdrawal notice from me. This form
has been read by me or has been read to me and I understand its meaning. Information provided
must be based on an examination within the last six months.

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Signature of applicant/licensee: ______________________________  Date:_______________
Print name of applicant/licensee: __________________________________________________

Signature of person authorized to consent (if not applicant): _____________________________
Print above name: __________________________________________  Date: ______________
Relationship to applicant/licensee: __________________________________________________

This page to be completed by applicant and given to physician to return to the Medical Advisory Board.

Physicians, please fax completed forms to:

(512) 834-6736

or mail to:

Medical Advisory Board
Texas Department of State Health Services
Regulatory Licensing Unit/Medical Advisory Board
(MC 1876)
PO Box 149347
Austin, Texas 78714-9909

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