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Authorization for Release of Medical Records

A copy of this release will be sent with Medical Records.

Please complete this form in its entirety so that we ensure that your records are transmitted correctly. The Physician/Facility phone and fax number are required for records to be released to the appropriate designated entity. Please allow up to ten days for the record request to be completed, unless specified as emergent, related to care. Any Incomplete fields may delay processing. The use of this information for any other reason than the stated purpose is prohibited. This information is for the use of the designated recipient only and cannot be provided to any other entity without express consent.

Reason for release of Information:
___Change of Insurance ___Moving ___Transfer of Care ___Specialist Consult ___Personal File ___Other

Please release all that apply:
___Recent H&P ___Lab Reports ___Hospital Reports ___Office Visits ___Xray Reports ___Other: _____

Authorization to release records <u>from</u>:
Physician/Facility Name and Address: _____
_____
Physician/Facility Phone number: _____
Physician/Facility fax number: _____

Patient's Name: _____
Patient's Address: _____
Patient's DOB: _____Patient's phone number: _____

Authorization to disclose records <u>to</u>: **Permission to fax records**? ___ Yes ___ No
Physician/Facility Name and Address: _____
_____
Physician/Facility Phone number: _____
Physician/Facility fax number: _____

I authorize the release of all information indicated, and I am aware that the records released may contain sensitive information that has been shared during treatment at our office. I authorize the release of any HIV/HTLV/AIDS test results, if applicable. I understand that I may be charged for the copies provided, not to exceed Texas code *22 Tex. Admin. Code § 165.2*

Signature of patient _____ Today's Date _____

Witness/Receiver_____ Today's Date _____

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