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Medical Records Release Form

By signing this form, I authorize you to release confidential health information on the patient(s) listed below, by releasing a copy of these medical records, or a summary or narrative of the protected health information, to the person(s) listed below.

Release my protected health information to the following person(s)/entity:

Name:____

Street:____

City:____________________State:__________Zip:________

The reason / purposes for this release of information are as follows:
(example: moving, change of insurance, etc)

____
____

PATIENT(S) NAME: ______________________ DOB:______________

____
Patient signature [or parent / guardian / legal representative] Date

____
Patient Phone Number

Limitations on the information you may release subject to this Release Form are as follows: ____
____

I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of medical records.

INITIAL: ____________________________ DATE: ____________

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.