Medical Records Release Form

By signing this form, I authorize ____

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______________________________________ Telephone #____________________

to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

HIV / AIDS: 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 my medical records. **Initial:** ______________ **Date:** __________________________

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

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

Name: ____

Street: ____

City: ____________________________ **State:** ________________ **Zip:** ______________

The reasons or purposes for this release of information are as follows:

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Patient Name: ______________________________________ **Acct. #:** ________________
DOB: ________________

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Patient Signature [or parent, guardian or legal representative]

Today's Date: ______________
This release will expire 6 months from the date it was signed, unless, it is revoked in writing.

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.