

Authorization For Release Of Medical Records

Patient Name _____ Date of Birth _____
Last First Middle

Street Address _____ City _____ State _____ Zip _____

Records Release Form:

Name _____ Phone # _____

Street Address _____ City _____ State _____ Zip _____

Record Release To:

Name _____ Phone # _____

Street Address _____ City _____ State _____ Zip _____

Type or extent of information to be released or received (check all applicable boxes):

- | | |
|---|---|
| <input type="checkbox"/> Medical history, examination reports | <input type="checkbox"/> Laboratory reports |
| <input type="checkbox"/> Operative reports | <input type="checkbox"/> Prescriptions |
| <input type="checkbox"/> Tests or treatments | <input type="checkbox"/> Consultations |
| <input type="checkbox"/> X-ray reports | <input type="checkbox"/> Other _____ |

Purpose Or Need For Release: _____

This authorization will remain in effect for ninety (90) days per Texas State Law. This authorization will be effective for medical records generated to the date of signature.

I understand I may revoke this authorization at any time by providing my written revocation.

X _____
Signature of Patient

Date

(If signed by someone other than patient, state relationship to patient.)

Patient is: Minor Incompetent Deceased

Legal Authority: Patient or legal guardian Next of kin of deceased