SWAT Surgical
Associates, L.L.P.

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):

- ☐ Medical history, examination reports
- ☐ Operative reports
- ☐ Tests or treatments
- ☐ X-ray reports
- ☐ Laboratory reports
- ☐ Prescriptions
- ☐ Consultations
- ☐ 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