

Authorization to Release Medical Records

Patient Name: _____

Address: _____

Date of Birth: _____ Social Security Number: _____

I hereby authorize the release of medical information FROM:

Friendswood Family Medicine
 300 E. Edgewood
 Friendswood, TX 77546
 Ph: 281-485-9034 Fax: 281-485-9807

To be released TO:

Check all that may be released:

Complete Records <input type="checkbox"/>	History <input type="checkbox"/>	Physical <input type="checkbox"/>	Progress Notes <input type="checkbox"/>
Lab Reports <input type="checkbox"/>	X-Rays <input type="checkbox"/>	EKG Report <input type="checkbox"/>	Operative Reports <input type="checkbox"/>
Psychological Reports <input type="checkbox"/>	Therapy Reports <input type="checkbox"/>	Care Plan <input type="checkbox"/>	Discharge Summary <input type="checkbox"/>
Other: <input type="checkbox"/>			

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or the treatment.

This authorization covers care provided from _____ to _____.

Purpose of disclosure:

- Medical Care Employer Insurance
 Attorney Other: _____

This authorization is valid for 180 days from the date of signature. Consent for authorization may be revoked at anytime in writing prior to the expiration date except to the extent disclosure made in good faith has already occurred in reliance on the consent. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and is no longer protected by this rule.

Date: _____

Signed: _____

(Patient or Representative)

 (Relationship to Patient)