Authorization to Release Medical Records

Patient Name: _____

Address: _____

Date of Birth: _____ Social Security Number: _____

I hereby authorize the release of medical information FROM:

_____

_____

_____

PLEASE ATTACH RECORDS TO THIS AUTHORIZATION. IF MORE THAN 50 PAGES PLEASE MAIL RECORDS.

To be released TO:

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

Check all that may be released:

Complete Records ☐	History ☐	Physical ☐	Progress Notes ☐
Lab Reports ☐	X-Rays ☐	EKG Report ☐	Operative Reports ☐
Psychological Reports ☐	Therapy Reports ☐	Care Plan ☐	Discharge Summary ☐
Other: ☐			

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)