FAMILY MEDICINE ASSOCIATES OF TEXAS, P.A.

Medical Records Authorization for Release of Medical Information

Patient Name: ______________________________ Date: __________

DOB: __________ SS#: ____________________ Phone #: ____________________

Address: (Street) ____

(City) ______________________________ (State) __________ (Zip) __________

BY STATE LAW YOU MUST BE ADVISED THAT: The information you authorize for release may include information regarding mental health, drug or alcohol use/abuse, communicable diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency virus also known as "AIDS".

I hereby authorize: ____

____

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Phone: ____________________ Fax: ____________________

Release the following health record information of the above-named patient, for the following purpose:

☐ Insurance ☐ Medical ☐ Other: ____________________

The information to be released is:

☐ All Records ☐ History & Physical Exam ☐ Consultation

☐ X-Ray Reports ☐ Operative Reports ☐ Lab / Pathology

☐ Other: ____

This information is to be released to: (Name) ______________________________

(Address) ____

Phone: ____________________ Fax: ____________________

This authorization will remain in force from the date of my signature until revoked upon written notification. Withdrawal of consent does not affect any information disclosed ***prior*** to the written notice of withdrawal. THERE MAY BE A FEE CHARGED FOR RECORD COPYING.

REDISCLOSURE: This information is being disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains.

______________________________ ______________________________

Witness Signature Date Patient/Legal Guardian Signature Date