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Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information.

Patient Name: ______________________________ D.O.B. _________________

Description of the specific information to be released:

____

Release my protected health information to the following person(s):

Name: ________________________________ Phone: _____________________

Name: ________________________________ Phone: _____________________

Name: ________________________________ Phone: _____________________

Name: ________________________________ Phone: _____________________

The reason or purpose for this release of information is as follows:

____

Patient Signature (or legal representative)

____ Date: _________________

I understand that you will provide this information within 15 days from date of request and that a fee for preparing and furnishing this information may be charged according to ruling set forth by the Texas State Board of Medical Examiners.

Witness: ____________________________________ Date: _________________

Permission is requested by patient to: [ ] Mail [ ] Hand Carry [ ] Fax