AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____

SS#: _____ DOB: _____

I, the undersigned, authorize the release of the information specified below from the medical record(s) of the above-named patient.

PATIENT INFORMATION IS NEEDED FOR:

☒ Continuing Medical Care	☐ Military	☐ Social Sec./Disability
☐ Insurance	☐ Personal Use	☐ Other: _____
☐ Legal Purposes	☐ School	

INFORMATION TO BE RELEASED:

☒ History & Physical	☒ Consultation Report	☒ Hospital Reports
☒ Operative Reports	☒ Discharge Summary	☐ Other: _____
	☒ X-ray Reports/Images	

RELEASE FROM: (Name of physician or facility releasing information)

_____

(Doctor, Hospital, Attorney, Insurance Company, Self, Other…) Phone Number

_____

Address (Street, City, State, Zip Code) Fax Number

RELEASE TO: (Name of physician or facility receiving information)

Dr. John Richardson (940) 627-0013

(Doctor, Hospital, Attorney, Insurance Company, Self, Other…) Phone Number

2301 S FM 51, Suite 500, Decatur, Texas 76234 (940) 627-1900

Address (Street, City, State, Zip Code) Fax Number

I understand that my records are confidential and cannot be disclosed without my written authorizations, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnosis and/or treatment of drug or alcohol abuse, mental illness or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs or the authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Hospital Law.

This authorization will expire in One Hundred Eighty Days (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event or condition as follows:

_____ _____

Date Signature Patient or Legally Authorized Representative

_____ _____

Relationship to patient Printed name of above signed