Authorization to Release Medical Records

Name of Patient ______________________________________ Date of Birth ________________________

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care

INFORMATION TO BE RELEASED OR ACCESSED SHOULD INCLUDE THE FOLLOWING:

- History & Physical
- Progress Notes
- EKG Tracings
- Lab/Path Reports
- Consultation Reports
- Immunization Record
- Radiology Reports
- Hospital Records
- Driver's License and Insurance Card
- Face Sheet
- Medication List

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO:

HILLCREST INTERNAL MEDICINE PH: 469-830-9600 / FAX: 469-830-9601
____
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

12720 Hillcrest Road, Suite 625, Dallas TX 75230
____
Address (Street, City, State and ZIP)

FROM:

____
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

____
Address (Street, City, State and ZIP)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

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.

The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Date: _________________ Signature: ____

Patient or Legally Authorized Representative

____
Printed Name of Patient or Legally Authorized Representative

____
Relationship to Patient