

MEDICAL RECORDS RELEASE REQUEST

Information to be Used or Disclosed

The information covered by this authorization includes:

_____ All available (including all mental health, alcohol/substance abuse and HIV)
_____ All available (excluding _____ mental health _____ alcohol/substance abuse _____ HIV)
_____ Lab/ Xray reports only
_____ Other _____

Purpose of Disclosure:

_____ Medical Care _____ Insurance
_____ Attorney _____ Other _____

Persons Authorized to Use or Disclose Information

Information listed above will be used or disclosed by:

Doctor/ Office name: _____
Address: _____
Phone: _____ Fax: _____

Person to Whom Information May Be Disclosed

Information described above may be disclosed to:

Dr. Patel
Alliance Family Medicine
11751 Alta Vista Ste. 101
Keller, TX 76248
Phone (817) 431-4224 Fax (817) 623-2009

Expiration Date and Right to Terminate or Revoke Authorization

This authorization shall be valid for 120 days from the date of signature. The patient can revoke this authorization at any time prior to the expiration date. I understand that you will provide this information within 15 days from receipt of the request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Patient Information

Printed Name _____ D.O.B.: _____
Address: _____
Signature: _____ Date: _____
Relationship to patient: _____
Other names records may be found under (i.e. nickname, maiden name, etc...) _____