Health@Care

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

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, to the person(s) or entity listed below.

Patients Name_____ Former Name_____

Social Security #_____ Date of Birth_____

Information to be released from:

Name: _____

Address: _____

Information to be released to:

Name: _____

Address: _____

(Please mail if over 25 pages)

Type of information to be released:

Complete Medical Records _____

Other (please specify) _____

HIV / AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:** **Date:**

The reasons or purposes for this release of information are as follows:
(must be completed for release to be valid)

_____

Patient Signature [or parent, guardian or legal representative]

_____**Date**_____

I understand that you will provide this information within 15 business days from receipt of 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.

Mailed_____

Please check the location you are visiting:

☐ 900 Jerome · Suite 400 · Fort Worth, TX · 76104 · Phone (817) 732-6060 · Fax (817) 731-2541

☐ 5801 Oakbend Trail · Suite 200 · Fort Worth, TX · 76132 · Phone (817) 529-9100 · Fax: (817) 529-9106