

Authorization for Release of Information

Records requested:

- Complete medical records.
- Records of care from _____ to _____ only.
- Other (please specify) _____
- Confer with another person orally about information in my record. Specify person under "TO".

Reason for Release: (Article 4495b, Sec. 5.08(j) Texas Revised Civil Statutes require that an authorization for release of medical records include "the reason or purpose for the release.")

- Change of Physician or Patient Moving Workers' Compensation or Disability Claim
- Application for Insurance Coverage Other: _____
- Consultation with another physician for (condition): _____

Records Requested FROM:

Send Records TO:

Physician's Name

Recipient's Name

Address

Address

City/State/Zip

City/State/Zip

(FAX including AREA CODE)

I understand that a reasonable amount of time (not to exceed 30 days) may be required to move my records. If possible, please send by: _____.

I, the undersigned, do hereby authorize the release of information described above from my medical records. I understand that reports may include information on drug/alcohol/psychological or communicable disease treatment. I understand that I may revoke this consent in writing at any time except to the extent that action has already been taken in reliance on it. A photocopy of this consent shall be considered valid. This authorization expires automatically in one year.

Patient's Full Name (Please Print): _____

Date of Birth: _____ Social Security #: _____ Year Last Seen: _____

Any other name(s) under which your records may be filed: _____

Patient's Signature

Date

(Patient or person legally authorized to consent on patient's behalf. State relationship to patient and reason patient is unable to sign.) (Revised 12/2019)