



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
Address
City/State/Zip

Recipient's Name
Address
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)