# Authorization for Release of

# MEDICAL RECORDS

Patient Name _____

Date of Birth _____ Social Security # _____

Address _____
Street City State Zip

**I Hereby Request and Authorize:**

Name _____

Address _____

Phone _____ Fax _____

**To Release and Send the Following Information:**

**Date(s) of service** (if known): _____

____Complete Record (including records from previous physicians or providers)

____Complete Hospital Record

____Records from _____ to _____ only.

____Records concerning the following condition(s) only: _____

**Release by Mail or Fax to:**

**Dr._____**
**Family Medical Associates**
**1175 Diane Circle**
**Lewisville, Texas 75067**

**(972) 436-7531 Fax: (972) 436-6114**

I consent to the release of my medical records for the following purpose:_____.
I further authorize the release of medical information which may contain facts about HIV infection, AIDS, AIDS Related Complex, other communicable diseases, mental illness, or drug and alcohol abuse. I understand that the requested information will be provided within 30 days from receipt of my request and that a reasonable fee may be charged. This authorization covers only the release of information documented prior to the date of this request and expires 90 days from this date. A photocopy of this authorization shall have the same force and effect as the original.

_____ _____

*Date of Request* *Patient Signature or Legal Representative*

_____

*Representative's Relationship to Patient*