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MEDICAL RECORDS REQUEST FORM

This authorizes you:

_____

_____Phone# _____ Fax # _____

To provide a copy, summary, or narrative of my medical records (as indicated by the checkmark (s) below) or otherwise release confidential information.

- ❑ Complete Record
- ❑ Records of care from the following dates: _____ to _____
- ❑ Records concerning the following conditions: _____
- ❑ Other, please specify: _____
- ❑ Confer with person(s) about my medical information: _____
- ❑ I do ❑ do not (check application box) authorize this information to be faxed.

The date, extent or condition upon which this authorization expires is _____ is not to exceed 24 months. I understand that this authorization my be revoked at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in ninety (90) days from the date below.

Release to the following person (s):

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

The reason or purposes for this release of information are as follows:

_____

_____

Patient Signature: _____ Date: _____

Print Name: _____

Patient's DOB: _____ Patient's SS#: _____-_____-_____

I understand that you will provide this information within 30 days from receipt of request and that a fee for preparing and furnishing this information will be charged according to rulings set forth by the Texas State Board of Medical Examiners.