Houston Family Practice

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Authorization for Release of Medical Information

I hereby authorize the release of information from the medical record of:

Patient Name: _____ Date of Birth: _____
Address: _____ Phone# _____
_____

Information Released To:
Name: **Houston Family Practice**
Address: **1200 Binz, Suite 175**
Houston, Texas 77004

Phone: **713.520.6016**
Fax: **713.520.7922**

From:
Name:
Address:

Phone:
Fax:

IF MORE THAN 25 PAGES PLEASE MAIL TO OUR OFFICE

Please Release the Following:

For the following dates of service – From_____ to _____

_____Complete medical record
_____ Consult
_____ Progress Notes
_____ History/Physical Exam
_____ Lab Reports
____Immunizations
_____X-Ray Reports
_____ EKG Reports
_____ Other Diagnostic Reports (Specify)_____
_____ Other (Specify)_____

Including information (if applicable) pertaining to:

_____ Mental Health _____Drug/Alcohol _____HIV/AIDS _____Communicable Treatment

Purpose of Need for Disclosure:

_____Continued Patient Care
_____ Attorney/Legal
_____ Disability Determination
_____ Personal Use
_____ Insurance Claim/Application
_____ Other (Specify)

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 1 year after the date of my signature unless otherwise specified.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.
I will not hold Houston Family Practice liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Witness

Date request completed_____ # pages copied _____ Initials _____