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RECORDS RELEASE AUTHORIZATION

Requesting only: (circle one)

Immunization records
Insurance information
Labs/x-rays

Physical form
All records
other: _____

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records: **Initial:** _____ **Date:** _____

Please send records requested (circle one) TO FROM

Clinic/Hospital/ School name: _____
Address: _____
Phone: _____
Fax: _____

Reason for records release: _____
For period of: _____

Patient name: _____ DOB: _____
Address: _____
City, State, Zip code: _____
Social security: _____

Responsible party name (printed): _____
Signature: _____
Date: _____

The personal health information contained in this fax is highly confidential. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare services to the patient. Any other use is in violation of the Federal Law, Health Insurance Portability and Accountability Act (HIPAA) and will be reported as such. I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners

**PLEASE ATTACH PICTURE ID
ONLY RESPONSIBLE PARTY CAN RELEASE RECORDS**

All lines must be filled out completely or records cannot be released.

For questions about medical records, please call 972-206-2940 EXT 208