

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

Patient's Name (Please Print)

Patient's Social Security # (optional)

Date of Birth

Phone Number

Release my protected health information to the following person(s)/entity:

From [ ] To [ ] Texas Sports & Family Medicine
3200 Red River, Suite 201
Austin, Tx. 78705
Phone: 512-473-0201
Fax: 512-473-0202

From [ ] To [ ]
Phone:
Fax:

For the purpose of:

Please release the following:

- Problem List
Progress Notes-from (date to)
Consultant Notes-from
Laboratory Results-from (date to)
Other Diagnostic Reports (Specify)
Other (Specify)

- X-ray/Imaging Reports
X-ray Films
Immunization Record
Medication List
EKG reports
Complete Medical Record

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
Yes, I consent to the release of this information. No, I do not consent to the release of this information.

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 understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:
If I fail to specify an expiration date, event or condition, this authorization will expire in six months.
I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Dr. Mark Hutchens at Texas Sports & Family Medicine, 512-473-0201.

Patient signature (or parent, guardian or legal representative)

Date:

Relationship to patient (If Legal Representative)

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 Texas Sports & Family Medicine 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

Date Released:

Released by:

Mailed to:

Notes: