Release of Medical Records

Patient Name_____ Date of Birth_____

Address_____

_____

Phone Number_____

Please release the following health information:

☐ All Medical Records ☐ Immunization Record only

☐ Lab and XRAY ☐ ER visit

☐ Other (describe)

The reason(s) for this release of information:

☐ Moving Out of Area ☐ Transferring Care ☐ Other (describe)_____

☐ **Obtain records <u>FROM</u>** ☐ **Release records <u>TO</u>**

Facility:_____

Address: _____

City: _____**State:**_____

Zip:_____

FAX: _____ **Phone:** _____

Please complete info in its entirety. A facility name and number or fax number is required to process this request. Incomplete information will delay this request.

This authorization shall be in force and effective 1 year from date of signature unless otherwise stated.

<u>Disclosures</u>

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the office. I understand that a revocation is not effective to the extent that the Organization has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified. I understand 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.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

Signature of Patient /Parent/Guardian/Authorized Representative

Printed Name of Patient/Parent/Guardian/ Authorized Representative

_____ _____

Date

Relationship to Patient

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Fax: 281-884-3558 ~ www.premierpediatricshouston.com