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 physician/person/facility/entity listed below.

Patient Name: _____Date of Birth: _____

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:**_____

The information you may release subject to this signed release form is as follows:

❑Complete Records ❑History & Physical ❑Progress Notes ❑Care Plan
❑Lab Reports ❑Radiology Reports ❑Pathology Reports ❑Treatment Record
❑Operative Reports ❑Hospital Reports ❑Medication Record ❑Other (please specify below)

_____

_____

Release my protected health information to the following physician/person/facility/entity:

Name:_____

Address:_____

City:_____State:_____Zip Code:_____

The purpose/reason for this release of information is as follows:

_____

I understand that Texas Cancer Associates will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

Signature:

_____ _____
Patient Name | Signature of Patient or Personal Representative

_____ _____
Patient Date of Birth or Social Security Number | Printed Name of Patient or Personal Representative

_____ _____
Date | Description of Personal Representative's Authority