

Medical Records Release Form

To: _____

This authorizes you to provide a copy, summary, or narrative of my medical records (as indicated by the checkmark(s) below) or otherwise release confidential information

- Complete record
- Records of care from the following dates: _____ to _____
- Records concerning the following conditions: _____
- Other, please specify: _____
- Confer with person (s) listed below orally about my medical information:

HV / 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:** _____

Release to the following person (s):

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

The reasons or purposes for this release of information are as follows:

The charge for copying records is \$25.00 and has to be paid prior to the release of any records. Fees for preparing and furnishing this information will be charged according to rulings set forth by the Texas State Board of Medical Examiners. Please allow a minimum of three (3) to thirty (30) business days for the records to be copied for pick-up or mailing.

Patient Signature: _____ Date: _____