Affiliates of Family Medicine

MEDICAL RECORDS RELEASE FORM

By signing this form, I agree and acknowledge the following:

Voluntary Authorization. This authorization is voluntary, treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

Effective Time Period: This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: _____.

Right to Revoke: I understand that I have the right to revoke this authorization at any time by writing to the healthcare provider or healthcare entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken on this authorization.

Special Information: This authorization may include the disclosure of information relating to **DRUG, ALOCHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

Signature Authorization: I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

PATIENT NAME:_____ **DOB:**_____

RELEASE FROM:_____

_____

_____

RELEASE TO: AFFILIATES OF FAMILY MEDICINE, P.A.

☐ **Leticia Garcia-Seay, MD** ☐ **Elena Garcia, MD**

☐ **Jed Jularbal, AGPCNP-BC** ☐ **Dora N. Aguilar, FNP-C** ☐ **Kimberly A. Hall, FNP-C** ☐ **Erin L. Weiss, FNP-C** ☐ **Maura Anderson, FNP-C**

☐ **503 Medical Center Blvd., Suite 100**
Conroe, TX 77304
Tel. (936) 788-1060 Fax (936) 788-2844

☐ **28517 Spring Trails Ridge, Suite 100**
Spring, TX 77386
Tel. (281) 362-5436 Fax (281) 651-5451

RELEASE FOLLOWING INFORMATION:

- ☐ Office Note_____
- ☐ Lab Work_____
- ☐ Radiology Reports_____
- ☐ Immunizations_____
- ☐ ER visit_____
- ☐ Other_____
- ☐ Entire record_____

INCLUDE (INDICATE BY INITIALING):

- _____Drug, Alcohol or Substance Abuse Records
- _____Mental Health Records (except Pyschotherapy notes)
- _____HIV/AIDS-Related Information (including HIV/AIDS test results)
- _____Genetic Information (including Genetic test results)

Patient/Parent/ Legal Representative's Signature: _____

Printed Name if Parent/Legal Representative:_____

Relationship to Patient if Parent/Legal Representative:_____

I understand that you will provide this information within 30 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.

OFFICE USE ONLY
FAXED:_____ MAILED:_____ PT PICK UP:_____

INITIALS:_____