1915 E. Mayfield Rd., Ste. 115
Arlington, TX 76014
Phone: (682)276-6700 Fax: (682)276-6049

Authorization to Release Health Information

Patient Information/Informacion del Paciente:

Name/Nombre del Paciente: ______________________________
Date of Birth/Fecha de Nacimiento: ______________
Address/Direccion: ______________________________
City, State, Zip/Ciudad, Estado, Código Postal: ______________________
Phone/Telefono: ______________________

Name of Releasing Facility/Nombre de la Facilidad enviando: *(Previous Doctor/Doctor Previo)* Name/Nombre: Address/Dirección: City, State, Zip/Ciudad, Estado, Código Postal: Phone/Teléfono: Fax:	***Send Records to/Enviar Archivos a:*** *(New Doctor/Doctor Nuevo)* Name/Nombre: Address/Dirección: City, State, Zip/Ciudad, Estado, Código Postal: Phone/Teléfono: Fax:

*****MEDICAL RECORDS THAT EXCEED 25 PAGES MUST BE RECEIVED BY MAIL ONLY*****
PLEASE DO NOT FAX
*****DISC FILES MUST BE IN TIF OR JPEG FORMAT ONLY***

INFORMATION TO BE RELEASED

- ☐ IMMUNIZATION RECORD ONLY/SOLO RECORD DE INMUNIZACION **PLEASE FAX SHOT RECORDS AS SOON AS POSSIBLE**
- ☐ MEDICAL RECORDS/HISTORIAL MEDICO- Date Range/Periodo de Fecha: __________ To/De__________ ☐ ALL/TODO
- ☐ TEST RESULTS/RESULTADOS DE PRUEBAS: (TYPE OF TEST/TIPO DE PRUEBA) _________Date/Fecha_________ ☐ ALL TESTS/TODAS LAS PRUEBAS
- ☐ OTHER/OTRO: ______________________________

This authorization will expire when I revoke this authorization in writing.

Patient Rights:

- **I may refuse to sign this authorization and I have the right to revoke this authorization in writing at any times.**
- **Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.**
- **Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law.**
- **I understand released health record may contain information in reference to Hepatitis B or C testing, HIV testing and or other sensitive information, including mental health and substance abuse.**
- **I understand that if I wish to have copies made, then the facility may assess a fee for copying the records. I will be notified of the total amount due for copying and shipping the requested records. I agree that the facility will only send me the requested information once it has received payment in full for those costs. I may inspect or copy the protected health information to be disclosed as described in this document.**
- **The personal health information contained in this fax is highly confidential. It is intended for the exclusive use of the addressee. It is to be used only to aid in the providing specific health acre services to the patient. Any other use is in violation of the Federal Law, Health Insurances Portability Accountability Act (HIPPA) and will be reported as such.**

Signature of Person Making the Request/Firma de la Persona solicitando: ______________________________
Date/Fecha: ______________
Print Name/Imprimir Nombre: ______________________
Relationship to Patient/Relacion con el Paciente: ______________