Medical Records Request Form

Patient Full Name:_____ Patient DOB:_____

Release Information From The Following:

Doctor Office/Facility Full Name:_____

Phone#:_____ **Fax#:**_____

Specific information to be disclosed:

□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, & films.

□ Entire Medical Record from (insert date) _____ to (insert date) _____

□ Other (Specify): _____

Include: (*Indicate By Initialing*)

_____ Drug, Alcohol or Substance Abuse Records

_____ Mental Health Records (Except Psychotherapy Notes)

_____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)

_____ Genetic Information (Including Genetic Test Results)

Reason For Release Of Information:

(Choose All That Apply)

□ Treatment/Continuing Medical Care

□ Other *(Specify)*: _____

Release Information To The Following:

Adult & Pediatric ENT & Allergy Of The Woodlands

17450 St Luke's Way, Suite 200 Phone: 936-321-2222

The Woodlands, Texas 77384 **Fax: 936-271-2223**

The individual signing this form agrees and acknowledges as follows:

Voluntary Authorization: This authorization is voluntary. A photocopy or fax of this authorization is as valid as the original. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.
Right to Revoke: I understand this authorization may be revoked in writing at any time, according to the instructions in Adult & Pediatric ENT & Allergy Of The Woodlands Notice of Privacy Practices, except to the extent that action had been taken in reliance on this authorization.
Special Information: This authorization may include disclosure of information relating to **DRUG, ALCOHOL** 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. If the person or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

This authorization is valid for 180 days unless otherwise specified here:_____

Minor Signature (if applicable):_____ **Date:**_____

Patient/Legal Guardian Signature:_____ **Date:**_____

Witness/Staff Signature:_____ **Date:**_____

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