

## Authorization to Release Medical Records

Name of Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

**PATIENT INFORMATION IS NEEDED FOR:**

Continuing Medical Care

**INFORMATION TO BE RELEASED OR ACCESSED:**

History & Physical

Consultation Report

Emergency Room Record

Operative Reports

Discharge/Death  
Summary

Face Sheet

Lab/Path Reports

X-Ray Reports/Images

Other: \_\_\_\_\_

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

**TO:**

Academic Medical Associates

Phone 972-445-9515 / Fax 972-445-9414

\_\_\_\_\_  
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.)

\_\_\_\_\_  
Phone Number

2021 N MacArthur Blvd, Suite 435, Irving TX 75061

\_\_\_\_\_  
Address (Street, City, State and ZIP)

**FROM:**

\_\_\_\_\_  
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.)

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Address (Street, City, State and ZIP)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Patient or Legally Authorized Representative

\_\_\_\_\_  
Printed Name of Patient or Legally Authorized Representative

\_\_\_\_\_  
Relationship to Patient