



AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

I hereby authorize:

NAME/FACILITY: _____

ADDRESS: _____

TELEPHONE # _____

to release the following information from the medical record of:

Patient name (please print) _____
Date of birth

INFORMATION MAY BE RELEASED ONLY TO THE FOLLOWING PARTY(S):

CCPN; 3535 FIREWHEEL DR, STE D; FLOWER MOUND, TX 75028 972-691-2388

The specific purpose(s) for this disclosure is/are:

- sharing with other healthcare providers**
- other** (please describe) _____

I WANT **I DO NOT WANT** (please check one) you to **INCLUDE** information pertaining to the diagnosis and/or treatment of HIV testing, AIDS, psychiatric illness, and alcohol and/or chemical abuse and dependency if any.

SPECIFIC INFORMATION TO BE RELEASED: (Please check all that you are requesting be released)

- Complete Medical Record for this Office**
- History & Physical**
- Other (Please List)** _____
- Immunization Records Only**
- Diagnostic Testing & Results**

- I understand that I may revoke this authorization at any time by notifying the office in writing at **ATTN: Practice Manager, Medical Record Request** of my intent to revoke this authorization, and that such revocation will not have any effect on any actions taken by the office before the revocation.
- *I understand this authorization expires 180 days from the date signed, unless otherwise revoked or noted: This consent is hereby extended for 1 year: Initials _____
Witnessed by _____*
- I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
- I understand that I may be asked to **show proof that I have the authority to sign** an authorization to review and/or receive copies of the above named patient's medical record which I am requesting.
- I understand that a photocopy or facsimile of this authorization is as valid as the original.

Signature of patient or patient's legally authorized representative

Date

Printed name of authorized representative

Relationship to patient