Authorization for release of Medical Records

Date _____

Last Name_____First Name_____Middle MI_____

DOB_____SSN_____

Home Address_____

City_____State_____Zip_____

Phone (Home)_____Phone (Cell)_____

I understand that the information in my health record may include disclosure of information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

I hereby authorize:

_____

_____

Phone_____ Fax_____

Release the following health record information of the above-named patient, for the following purpose:

□ Insurance □ Medical □ Other

The information to be released:

□ All records □ X-Ray reports □ History and Physical exams □ Lab/Pathology reports □ Billing records □ Other _____

This informtion is to be released to:

Nest Family Medicine
4920 McDermott Rd, Suite 200, Plano, TX 75024
Phone – 972 200 5666
Fax – 972 294 5858

This authorization will remain in force from the date of my signature until revoked upon written notification. Withdrawal of consent does not affect any information disclosed prior to the written notice of withdrawal.

This information is being disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains.

Patient Signature _____Date_____