



MEDICAL CLINIC OF HOUSTON L.L.P.
Medical Records and X-Ray Release Authorization Form
SUNSET CLINIC/MEDICAL CENTER

1701 Sunset Boulevard
Houston, Texas 77005-1713
(713) 526-5511 (Main Line)
(713) 526-0451 (Medical Records Fax) / (713) 520-4728 (Radiology Fax)

I hereby authorize _____
Facility / Physician Name

To release information from the medical records of _____
Last First MI

To: _____
Name / Address of person / organization to which disclosure is to be made

Phone # _____ Fax # _____

Patient's Name _____ Date of Birth _____

Social Security # _____ MCH # (if known) _____

PURPOSE OF DISCLOSURE

- Attorney/Legal, Insurance Policy Approval, Physician No Longer Accepts My Insurance, Insurance Claim Processing, Workers' Compensation, Continued Patient Care, Personal Use, Review of Medical Records, Moving, Second Opinion, Referral, Other

Please Provide Date Medical Records Are Needed By _____

INFORMATION TO BE RELEASED

Federal Regulation (42CFR Part 2) and/or Texas Law Article 4495B, Section 5.08

COPY OF (COMPLETE) HEALTH RECORD (Information obtained in the course of treatment from other hospitals, physician's offices, clinic, any other medical institutions, etc. will not be included, unless selected below.)

RELEASE ONLY THE SPECIFIC RECORDS CHECKED:

- Physician Lab Notes, ECG/Non-Invasive Cardiology Reports, Lab Reports, X-Ray Films, X-Ray Reports, Specific Dates of Service, Other, Copies of Records from other health care facilities and/or providers which are retained in the MCH Record.

SENSITIVE INFORMATION CONCERNING DIAGNOSIS, TREATMENT, AND/OR STATUS OF ACQUIRED IMMUNE DISEASE (HIV), SEXUALLY TRANSMITTED DISEASES, MENTAL CONDITION(S), AND/OR DRUG AND ALCOHOL ABUSE WILL BE RELEASED UNLESS SIGNED HERE

X _____

I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. It is further understood that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization, or person.

I understand that correspondence, patient discharge instructions, and records from other health care providers will not be released with this routine request unless specifically requested above. This consent will expire 90 days after date of signature. Medical Clinic of Houston L.L.P., its employees and partners and attending physician(s) are released from legal responsibility for the release of the above information to the extent indicated and authorized herein.

Signature X _____ Date _____

Witness X _____ Date _____

* If the patient is unable to sign this request, please provide a Power of Attorney/Declaration of Heirship or a copy of the Patient's Death Certificate if the patient is Deceased.

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information that has been written in the record.

I will not hold Medical Clinic of Houston L.L.P. liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Patient Signature X _____ Date _____

* Fees/charges will comply with all laws and regulations applicable to release of Protected Health Information