



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

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

Phone DOB Social Security (Last 4 Digits) MCH # (if known)

To: Name of person / organization to which disclosure is to be made Phone #

Address of person / organization to which disclosure is to be made

PURPOSE OF DISCLOSURE

- Attorney/Legal Insurance Policy Approval Physician No Longer Accepts My Insurance
Insurance Claim Processing Workers' Compensation Continued Patient Care (Please Provide Physician's Specialty)
Personal Use Referral Moving
Other

INFORMATION TO BE RELEASED

Federal Regulation (42CFR Part 2) and/or Texas Medical Board Chapter 165

- COPY OF (COMPLETE) HEALTH RECORD (Information obtained in the course of treatment from other hospitals, physicians' offices, clinics, or any other medical institutions, will not be included, unless selected below.)
Copies of records from other health care facilities and/or providers which are retained in the Medical Record.

RELEASE ONLY THE SPECIFIC RECORDS CHECKED:

- Physician Notes ECG/Non-Invasive Cardiology Reports Lab Reports Itemized Bill
X-Ray Films X-Ray Reports Specific Dates of Service
Other - Specify:

NON-DISCLOSURE OF SENSITIVE INFORMATION

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

Patient Signature X

I understand this consent can be revoked by submitting a request in writing to the Clinic's Privacy Officer at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent.

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.

I understand that the 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 the medical record to prevent my misunderstanding of the information that has been written in the medical record.

Medical Clinic of Houston, L.L.P. will not condition my treatment on whether I sign this authorization.

Signature of Patient or Legal Representative Date

Printed Name (if other than patient)

Relationship (circle) Parent/Conservator/Guardian/Other
If the patient is unable to sign this request, please provide a Medical Power of Attorney, Declaration of Heirship, or a copy of the patient's Death Certificate if the patient is deceased.

Fees/charges will comply with all applicable laws and regulations.