



Medical Records Release Form - Garland office – Drs. Salter, Bascom, Lux

Business office phone **972-644-2819** Business office fax **972-680-2949** **A fee may be assessed for copies of records.**

By signing this form, I authorize Health Central Women's Care, P.A. to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____ Date of Birth: _____

Date(s) of Service: _____ Social Security Number: _____

The information you may release subject to this signed release form is as follows:

- Complete Records
 History & Physical
 Progress Notes
 Care Plan
 Lab/Pathology Reports
 Consultation Reports
 Discharge/Death Summary
 Treatment Record
 Operative Reports
 Hospital Reports
 Medication Record
 Other _____

Release my protected health information to the following physician/person/facility/entity:

Name: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip Code: _____

The purpose/reason for this release of information is as follows:

- Permanent Transfer
 Personal Copy
 Legal
 Insurance Application
 Other (please describe) _____

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 redisclosure 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 Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. 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. I understand I may be charged a reasonable fee for copies of my medical records in accordance with Section 165.2 of the Texas Administrative Code.

This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event or condition as follows:

Signature:

Patient or Legally Authorized Representative

Printed Name of Patient or Legally Authorized Representative

Relationship to Patient

Date