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4412 Kell Blvd
Wichita Falls, TX 76309
(940) 696-0011
(940) 696-2248 (Fax)

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Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me. Please release a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

*Patient Name: ____________________

*Social Security Number: ____________ *DOB: ____________

Records to be sent from the following facility:

Physician's Name/Clinic: ____________________

Address: ____________ City, State, Zip: ____________

Phone: ____________ Fax: ____________

Limitations:

☐ Complete record

☐ Records of care from the following dates: ____________ to ____________

☐ Records concerning the following conditions: ____________

☐ Confer orally with person(s) or entity listed below about my medical information.

☐ Other, please specify: ____________

HIV/AIDS: I consent to the release of any positive or negative test result for HIV or AIDS infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. Initial: _______ Date: __________

Release my protected health information to the following person(s) or entities:

☐ Harmony Integrative Medicine Clinics
4412 Kell Boulevard
Wichita Falls, TX 76309
940.696.0011 Fax: 940.696.2248

☐ Other: ____________
Address: ____________
____
Phone: ________ Fax: ________

The reason or purpose for this release of information is ____________

I understand you will provide this information within fifteen days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas Board of Medical Examiners.

____________________ ____________
Signature of Patient or Personal Representative Date

____
Printed Name of Patient or Personal Representative

____
Description of Personal Representative's Authority