Jon-Cecil Walkes, M.D. (Cardiothoracic & Vascular Surgery)
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MEDICAL RECORD RELEASE FORM

By signing this form, I authorize you 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, or entity listed below.

PATIENT NAME: ____DATE OF BIRTH______________

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

[ ] Complete Records [ ] History & Physical [ ] Progress Notes

[ ] Care Plan [ ] Lap Reports [ ] Radiology Reports

[ ] Pathology Reports [ ] Treatment Record [ ] Operative Report

[ ] Hospital Reports [ ] Medication Record [ ] Other (please specify)

Release my protected health information to the following physician, person, facility, entity, and/or those directly associated in my medical care:

NAME: ____

ADDRESS: ____

CITY, STATE, ZIP CODE: ____

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

____

____

281.888.0809 OFFICE WWW.THVMG.COM 877.559.7682 FAX
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Signature

______________________________	______________________________
Patient Name	Signature of Patient or Personal Representative
______________________________	______________________________
Patient Date of Birth or Social Security #	Printed Name of Patient or Representative
______________________________	______________________________
Date	Description of Personal Representative's Authority