3201 Highway 380, Suite 201
Cross Roads, TX 76227

(PHONE) 940.365.3030 **(FAX) 940.365.3032**

Authorization for Release of Medical Records

Name of Patient: _____

Address: _____

Telephone: _____ **Fax:** _____

Date of Birth: _____

I authorize Cross Roads Hormonal Health **to:**

☐ ***Release*** **information** ***to*** **the individual/organization identified below**

☐ ***Obtain*** **information** ***from*** **the individual/organization identified below**

Please provide copies of my records concerning (my child/myself) which may include but may not be limited to: history and physicals, progress notes, consultations, operative notes, discharge summaries, diagnostic films, laboratory/pathology reports and other diagnostic reports. I understand that the information may also contain information from other healthcare providers as well as administrative data which is not strictly medical in nature. I am aware that some of this information may contain sensitive material with regard to alcohol and drug abuse, sexually transmitted disease, behavior or mental health, HIV/AIDS, hepatitis, or other communicable diseases**.**

This information is being requested for the purpose of:

_____

Medical Facility Permitted to Receive or Send the Information:

Name of Medical Facility:_____

Address:_____

Telephone #: _____ **Fax #**_____

Expiration: This authorization shall remain in effect 6 months from date of signature unless otherwise advised by patient, parent, or guardian.

Signature Date

Email to**:** smile@crwhealth.com