Hope Internal Medicine & Sleep

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Phone: 817-770-0933
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Medical Record Release Request

Patient Name:_____ Date of Birth_____

Address_____ City_____ State_____ Zip_____

Social Security_____ Phone #_____

The following facility is authorized to provide copies of the patient's identifiable health information:

Release From:

Name:_____

Address:_____

Phone:_____ Fax:_____

Send To:

Name:_____

Address:_____

Phone:_____ **Fax:**_____

Purpose for releasing the information

( ) Moving away from area ( ) Transfer of Care ( ) At Patient Request ( ) For Patient Care

Describe information to be released

( ) Office/Treatment notes ( ) Lab ( ) Imaging (X-ray,CT,MRI) ( ) EKG ( ) Other_____

PLEASE INDICATE DATES OF SERVICE TO BE RELEASED

( ) Entire Medical Record for services rendered at this office

( ) Last office Note ,laboratory and /or x-ray test results

( ) Other (please specify)_____

I understand that if my records contain documentation of Alcohol Abuse,Psychiatric condition,drug abuse,or communicable disease,this information will be released as pat of my record.

I understand that if the person or facility receiving this information is not covered by federal provacy regulations,this information will no longer be protected and may be re-disclosed.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

I understand that I may revoke this authorization at any time,but revocation will not apply to information thar has already been released.

Note: The revocation must be in writing and delivered to the above address of the person/ enitity of whom was to release information.

I understand that unless earlier revoked,this authorization will expire 30 days after the date signed.

I understand that there may be a charge for obtaining the requested information,Related charges can be obtained by contacting the medical records department

I understand that I have the right to obtain a copy of this authorization .

Patient signature:_____ Date:_____