P.L. Allen M.D.

Medical Records Release Form

7560 Glenview Dr., Suite 106
North Richland Hills, TX 76180
Ph: (817) 590-8700 Fax: (817) 590-8200
www.drpatrickallen.com

Patient Name (**please print**): _____Address: _____

City:_____ State:_____ Zip:_____

DOB:_____ Phone #:_____

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

Release my protected medical information **FROM** or **TO** the following entity: (circle one)

Physician:

Address: _____

City/State/Zip: _____

Phone: _____ Fax:_____

Reason: _____

Please release the following:

- □ Office Notes
- □ Medication List
- □ Lab Work
- □ X-Ray/Imaging Reports
- □ Diagnostic Reports
- □ Pathology Reports
- □ Entire Record
- □ Other:

I understand that you will provide this information within 15 business days from receipt of request and payment of any fee for preparing and furnishing this information according to the rulings set forth by the Texas State Board of Medical Examiners.

HIV/AIDS: I consent to the release of any positive or negative test result of AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS, STD's, mental health and substance abuse with the rest of my medical records. Initials:_____

This authorization will expire three hundred sixty five (365) 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:

_____

Patient Signature:_____ Date:_____

_____ _____

Relationship to Patient or Legal Representative Date