MEDICAL CLINIC OF HOUSTON, L.L.P.

Medical Records and X-Ray Release Authorization Form

1701 Sunset Boulevard
Houston, Texas 77005-1713
(713) 526-5511 (Main Line)
(713) 526-0451 (Medical Records Fax) / (713) 520-4728 (Radiology Fax)

I hereby authorize _____
Facility / Physician Name

To release information from the medical records of _____
Last First MI

Phone _____ DOB _____ Social Security (Last 4 Digits) _____ MCH # (if known) _____

To: _____ Phone # _____
Name of person / organization to which disclosure is to be made

_____
Address of person / organization to which disclosure is to be made

PURPOSE OF DISCLOSURE

☐ Attorney/Legal ☐ Insurance Policy Approval ☐ Physician No Longer Accepts My Insurance
☐ Insurance Claim Processing ☐ Workers' Compensation ☐ Continued Patient Care (Please Provide Physician's Specialty)_____
☐ Personal Use ☐ Referral ☐ Moving
☐ Other _____

INFORMATION TO BE RELEASED
Federal Regulation (42CFR Part 2) and/or Texas Medical Board Chapter 165

☐ **COPY OF (COMPLETE) HEALTH RECORD** (Information obtained in the course of treatment from other hospitals, physicians' offices, clinics, or any other medical institutions, will not be included, unless selected below.)

☐ Copies of records from other health care facilities and/or providers which are retained in the Medical Record.

RELEASE ONLY THE SPECIFIC RECORDS CHECKED:

☐ Physician Notes ☐ ECG/Non-Invasive Cardiology Reports ☐ Lab Reports ☐ Itemized Bill
☐ X-Ray Films ☐ X-Ray Reports ☐ Specific Dates of Service _____
☐ Other - Specify: _____

NON-DISCLOSURE OF SENSITIVE INFORMATION

SENSITIVE INFORMATION CONCERNING DIAGNOSIS, TREATMENT, AND/OR STATUS OF ACQUIRED IMMUNE DISEASE (HIV), SEXUALLY TRANSMITTED DISEASES, PSYCHIATRIC CONDITION(S), AND/OR DRUG AND ALCOHOL ABUSE WILL BE RELEASED UNLESS SIGNED HERE.

Patient Signature X _____

I understand this consent can be revoked by submitting a request in writing to the Clinic's Privacy Officer at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected.

I understand that correspondence, patient discharge instructions, and records from other health care providers will not be released with this routine request unless specifically requested above. This consent will expire 90 days after date of signature. Medical Clinic of Houston L.L.P., its employees, partners, and attending physician(s) are released from legal responsibility for the release of the above noted information to the extent indicated and authorized herein.

I understand that the medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in the medical record to prevent my misunderstanding of the information that has been written in the medical record. I will not hold Medical Clinic of Houston L.L.P. liable for any misinterpretation of the information in the medical record as a result of not consulting my physician for the correct interpretation.

Medical Clinic of Houston, L.L.P. will not condition my treatment on whether I sign this authorization.

_____ **Date**_____
Signature of Patient or Legal Representative

_____
Printed Name (if other than patient)

Relationship (circle) Parent/Conservator/Guardian/Other_____
If the patient is unable to sign this request, please provide a Medical Power of Attorney, Declaration of Heirship, or a copy of the patient's Death Certificate if the patient is deceased.

Fees/charges will comply with all applicable laws and regulations.