AUTHORIZATION FOR OBTAINING MEDICAL RECORDS

Please fax records to: **817-346-3491**

Must be completed in order to release information

PATIENT NAME *Last: _____ *First: _____ MI: ____ Maiden Name: _____

*Date of Birth: _____ Social Security Number: XXX-XX-_____

I hereby authorize the release of information concerning my treatment from:

*Facility Name: _____

* Address: _____

*City, State, Zip: _____

*Phone: _____ *Fax: _____

***Information Requested:**

☐ Entire Record

☐ Other (Specify)

_____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides the insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization expires in 180 days upon completion of this request.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION, WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE, WHICH MAY INCLUDE BUT ARE NOT LIMITED TO, DISEASE SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, HUMAN IMMUNODEFICIENCY VIRUS (HIV), AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). I ALSO UNDERSTAND THAT PSYCHIATRIC (INCLUDING DEPRESSION) AND/OR CHEMICAL DEPENDENCY CONDITIONS AND/OR MEDICATIONS FOR THESE CONDITIONS MAY BE CONTAINED IN MY MEDICAL RECORDS AND CANNOT BE SEPARATED DURING PROCESS OF COMPLYING WITH MY REQUEST FOR SUCH INFORMATION.

_____ _____

*Signature of Patient or Parent/Guardian of Minor Child *Date