PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:____ Date of Birth:______________________

Address:____ Telephone: (____)_____-_______

I hereby authorize:

________________________________ ________________________________ ______________________________
Name of Provider/Hospital/Physician Provider/Hospital/Physician Address Telephone Number

To release the following information from my health record covering the period of From_________________ to______________, if I do not specify a period I am authorizing the release of records for entire duration of care with the provider. *(check all that apply below)*

☐ Complete Medical Record (includes information regarding insurance, demographic, referral documents, and medical Records). ***If this box is checked, do not check any additional boxes.***

☐ Progress/Office Visit Notes ☐ Radiology/Imaging Reports ☐ Chemotherapy/Radiation Records

☐ Lab Reports ☐ Pathology Reports ☐ Billing/Payment Records

Information is to be released to:
Genesis Medical Group______________________________Telephone: (_____)_____-_______Fax: (_____)_____-_______
Office Address

The information is being released for the following purposes:

☐ Continued Care/Treatment ☐ Disability ☐ Attorney/Litigation ☐ Other___________________

I understand that this authorization will remain in effect until I revoke it in writing.
I understand that according to applicable state and or/federal laws (Texas Medical Practice Act or Health Insurance Portability and Accountability Act), a re-disclosure could be made of records received from another physician or other health care provider involved in my care or treatment

____________________________________ ______________________________________ ______________
Patient/Legal Representative Print Name Patient/Legal Representative Signature Date

☐ **REVOKE/CANCEL THIS AUTHORIZATION**

__________________________________ ________________
Patient/Legal Representative Signature Date