Medical Records Release

Lake Arlington Family Medicine
Pediatric & Adult Care

2309 W. Green Oaks Blvd
Arlington, TX 76016

Phone: 817-496-4957
Fax: 817-496-3783

Patient Name _____ **DOB** _____

I hereby authorize: _____ To release records to: _____

Address _____ Address _____

City, State, Zip _____ City, State, Zip _____

Phone _____ Phone _____

Fax _____ Fax _____

- ☐ Entire Medical Record
- ☐ Operative Reports
- ☐ Lab Reports
- ☐ Consultations
- ☐ Radiology Reports
- ☐ Radiology Films
- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Other (Specify):

Date Range: _____

The information specified above is to be released for the following purpose only:

_____

(Article 4498, Section 5.08 Texas Revised Civil Statues, required that the reason or purpose for release to be listed.)

I understand that the specific type of information disclosed will include drug and alcohol/mental health, communicable diseases including HIV test results and AIDS related information if applicable.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. This authorization will automatically expire six (6) months from the date of my signature unless revoked prior to that time unless otherwise specified by date, event, or condition as follows:

_____

Federal Law (43 CFR part 2) prohibits redisclosure of this information for this recipient.

_____

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

Relationship to Patient: _____

Witness: _____ Date _____

A legal representative includes ONLY (1) the parent of a minor (2) the court appointed guardian of a minor or incompetent patient (Court order appointing guardian MUST accompany this form (3) a person or agent for the patient under a durable power of attorney for health care (4) the executor or administrator of the estate of a deceased patient (copy of court order appointing executor or administrator MUST accompany this form)