

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____ Date of Birth: _____

The information you may release subject to this signed release form is as follows:

- | | | |
|--|---|---|
| <input type="checkbox"/> Complete Records | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Care Plan | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Treatment Record | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Hospital Reports
(below) | <input type="checkbox"/> Medication Record | <input type="checkbox"/> Other (please specify) |

Dates: _____ to _____

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Name: Community Health and Life Center, PLLC
Address: 17510 W. Grand Parkway South, Suite #380
City: State: Zip Code: Sugar Land, TX 77479

The purpose/reason for this release of information is as follows:
Continuity of Care

Signature:

Patient Name

Signature of Patient or Personal Representative

Patient Date of Birth or Social Security Number

Printed Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority



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