

### AUTHORIZATION FOR RELEASE OF INFORMATION

**Records requested:**

\_\_\_ Complete medical records. (Initial and date box below if HIV/AIDS test results are to be included.)

\_\_\_ Records of care from \_\_\_\_\_ to \_\_\_\_\_ only.

\_\_\_ Other (Please specify) \_\_\_\_\_

\_\_\_ Confer with another person orally about information in my record. Specify person under "TO".

**HIV/AIDS. I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.**

**Initial:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Reason for Release:** (Article 4495 b, Sec. 5.08(j) Texas Revised Civil Statutes requires that an authorization for release of medical records include "the reasons or purposes for the release.")

\_\_\_ Change of Physician  
\_\_\_ Patient Moving  
\_\_\_ Application for Insurance Coverage  
\_\_\_ Consultation with another physician for (condition) \_\_\_\_\_

\_\_\_ Workers' Compensation or Disability Claim  
\_\_\_ Other: \_\_\_\_\_

**Records Requested FROM:**

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/Zip

**Send Records TO:**

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
(FAX including Area Code)

I understand that a reasonable amount of time (not to exceed 15 days) may be required to retrieve my records. A fee may be charged according to TMA guidelines. The maximum fee will be \$25 for 1-20 pages and 15 cents for each page thereafter. The fee will be payable in advance.

\_\_\_ The fee is waived because the records are to be used for supporting an application for disability or other benefits or assistance under Aid to Families with Dependent Children, Medicaid, Medicare, Supplemental Security Income, or Federal Old-Age and Survivors Insurance and a statement is attached, which confirms that such an application or appeal has been filed or is pending.

**I, the undersigned, do hereby authorize the release of information described above from my medical records. I understand that reports may include information on drug/alcohol/psychological or communicable disease treatment. I understand that I may revoke this consent in writing at any time except to the extent that action has already been taken in reliance on it. A photocopy of this consent shall be considered valid. This authorization expires automatically in one year.**

Patient's Full Name (Please Print): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_ Year Last Seen: \_\_\_\_\_

Any other name(s) under which your records may be filed: \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Patient or person legally authorized to consent on patient's behalf. If not patient, state relationship to patient and reason patient unable to sign.)