

## MEDICAL RECORDS RELEASE

### I AUTHORIZE THE USE/DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

#### Person (s) or Organization (s) authorized to provide the information:

Release Records: Complete Care Physicians  
TO \_\_\_\_\_ 25314 Kingsland  
FROM X \_\_\_\_\_ Katy, Texas 77494  
O: (832) 508-6632 F: (832) 437-1640

Release Records: Name / Facility \_\_\_\_\_  
TO X \_\_\_\_\_ Address: \_\_\_\_\_  
FROM \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_ Pt \_\_\_\_\_

**A. Records from Complete Care Physicians WILL be FAXED. Any paper copies will incur a fee per state regulatory board.**

**B. This information is to include: COMPLETE MEDICAL RECORDS OR \_\_\_\_\_**

**C. These records are to be used for continued medical treatment.**

I understand that this authorization will expire one year from the date signed unless noted.

1) I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying the person or organization mentioned in A (above) in writing.

2) I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment.

3) I may inspect or copy any information used or disclosed under this agreement.

4) I understand that if person or organization that receives the information is not a health care provider or plan covered by Federal Privacy Regulations, the information described above may be redisclosed and would no longer be protected by these regulations:

5) For paper copies, a maximum of \$25 for the first 20 pages and \$0.50 per page thereafter is allowed according to state regulations.

\_\_\_\_\_  
Patient's Signature or Patient's Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Representative

\_\_\_\_\_  
Relationship to Patient