Authorization and Request for Release of Medical Records

To:_____

_____

_____

Date: _____

Patient Consent:

I acknowledge that my medical records are legally protected from casual access and that my expressed permission is required to allow any information to be released. By signing this form, I authorize you to release confidential information about myself or dependent. I hereby authorized you to release all pertinent information regarding care, including the diagnosis and records of examinations or treatment rendered by your office. Please release this protected health information to:

Dr. Stephen B. Trammell
Ovilla Medical Clinic
675 W. Main St
Ovilla, TX 75154
972-617-6376 office
972-617-6381 fax

Specific Information Requested:_____

_____

_____

Reason:_____ Continuation of care ____Change in providers ____ Update PCP

I understand that my expressed consent is required to release any healthcare information relating to testing, diagnosis and/or treatments for HIV antibody, sexually transmitted diseases, psychiatric disorders, mental health disorders or drug/alcohol usage. You are specifically authorized to release all healthcare information relating to any such diagnosis that is being treated or has been treated. I understand that this authorization is in effect for 180 days following the date of signature and I understand this authorization may be revoked, at any time, by giving written notice to Dr. Trammell's office.

Patient's Name:_____ DOB: _____

Address:_____

Patient's/Adult Guardian's signature: _____

Relationship to patient: _____