Medical Records Release Form

Patient Name: _____

Social Security #: _____ Date of Birth: _____

Address: _____ City: _____ State _____ Zip _____

Home Phone #: _____ Alternate Phone #: _____

I hereby authorize:

_____

_____

_____

To release the following information:

_____Full complete medical records held by their office
_____Medical records for the period of _____ through _____
_____Billing Information
_____Other-Please specify the portion/section of the medical record as follows:

_____

_____

Information is to be released to the following:

Alpha Medical Center
2505 W Beltline Road
Lancaster Texas 75146
(972) 230-8290
(972) 230-8274

I understand that if I choose I may revoke this authorization before 90 days. If revocation is not received in writing, this authorization will be considered valid for a period of time not to exceed 90 days.

I understand that the information released could contain reference to or results of HIV antibody (AIDS) testing.

Alpha Medical Center and its employees are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized. A photo static copy of this authorization is to be considered as valid as the original. Also a charge of $25.00 for copy of records is due upon pickup.

Patients printed name: _____Date:_____

Patients Signature: _____Date:_____

Guardian: _____Relation to Patient:_____