RELEASE OF MEDICAL RECORDS

Date: _____

Re: Patient Name: _____ Date of Birth: _____

Gender: _____

Dear Dr. _____:

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the checkmark(s) below or otherwise release confidential information:

_____ Complete record
_____ Record of care from _____ to _____, only
_____ Record of care concerning the following condition(s) _____
_____
_____ Other, specify: _____
_____ Confer with another person orally about information in my medical record

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 record.

Initial: _____ Date: _____

to the following person(s):

Name: _____
Street: _____
City: _____ State: _____ Zip: _____

The reason or purpose for this release of information is as follows: _____

_____

I understand that you will provide this information within 15 days from receipt of request (per Medical Practice Act of the Texas State Board of Medical Examiners) and that a fee for preparing and furnishing this information may be charged. (The fee will be waived if the records are to be used for supporting an application for disability or other benefits or assistance under a) Aid to Families with Dependent Children, b) Medicaid, c) Medicare, d) Supplemental Security Income, and e) Federal Old-Age and Survivors Insurance. I have attached a statement that confirms that such an application or appeal has been filed or is pending).

Signed: _____ Date: _____

(Patient or person legally authorized to consent on patient's behalf)