CORRIDOR PRIMARY CARE INTERNAL MEDICINE
601A Leah Ave
San Marcos, Texas 78666
PHONE: (512) 396-1000 FAX: (512) 353-2554
REQUEST FOR RELEASE OF MEDICAL RECORDS

Patients Name:_____ DOB: _____

I understand that my/my child's medical records are confidential and cannot be disclosed without my written authorization, except otherwise provided for by law. I hereby voluntarily authorize the health information regarding the above named person to be exchanged between

From: _____ To: _____

Address: _____ Address: _____

City/State/Zip: _____ City/State/Zip:_____
Phone: _____ Phone: _____
Fax: _____ Fax:_____

The specific purpose(s) for this disclosure is/are:

( ) My personal Use

( ) Sharing with other Healthcare provider

( ) Other (Specify) _____

( ) I want ( ) do not want you to include information pertaining to the diagnosis and /or treatment of HIV testing, AIDS, psychiatric illness, and alcohol or chemical abuse or dependency if any.

Specific Information to be released: (Please check all that apply)

___ Complete Medical Record ____Immunization record only ___Lab/X-Ray

____History & Physicals ____Progress note ____D/C Summary

____Other _____

* I understand that I may revoke this authorization at any time by notifying the office in writing.
* I understand this authorization expires 180 days from the date signed unless otherwise revoked.
* I understand that once the above information is disclosed it may be re disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
* I understand that a photocopy or facsimile of this authorization is as valid as the original.

_____ _____
Date Signature of patient, parent or authorized guardian

_____
Print Name