

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