MEDICAL RECORD RELEASE FORM

El Paso, TX 79936
Telephone: 915-591-7704
Fax: 915-591-7734

_____ _____

Patient Name and date of birth Date

_____ _____

Address Phone #

I authorize:

Name_____ Telephone #_____

Address_____ Fax #_____

To release medical information to:

Name_____ Telephone #_____

Address_____ Fax #_____

[ ] All records

[ ] Specific Records from _____ to_____

[ ] Immunizations & Physical Examinations

[ ] Radiology Reports (X-ray, Ultrasound, CT, MRI, etc.)

_____ _____

Signature of Patient or Legal Guardian Date

_____

Relationship to Patient

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical and/ or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have I the right to revoke this consent at any time and that it must be done in writing unless the facility, which is to make the disclosure of information, has already done so in reliance on the statement.