Authorization Form
Release of Information/Medical Records
Dr. Jessica Holt
929 Gessner Rd, # 2225
T: 713-906-7998
F: 866-594-8432

This form when completed and signed by you authorizes Dr. Holt to exchange protected information from your clinical records to, from and/or both, with the person you designate. We will not release any information regarding appointments, treatment, etc., without a release of information on file. *This form is optional – if you do not have anyone to release information to and/or need to get information from, you do not have to fill out this form.*

Please circle the type of release that is being authorized and fill out all the information below regarding whom your release applies to (such as a physician, counselor, family member, friend, hospital, facility, etc.)

I authorize Jessica B. Holt, MD to do one of the following:

Release Records to: *OR* **Receive Records from:** *OR* **Release to *and* receive records from:**

Name:_____

Address:_____

City, State:_____ Zip Code:_____

Phone:_____ Fax:_____

This request applies to the following protected health information – check all that apply:

____ **All information**

____ Appointments only

____Billing Reports

____Medication only

____Laboratory Reports

____ Office Notes

____Other – please specify:_____

I am requesting the release of this information for the following reason *(circle one)*:

Transfer of care **Coordination of Care** **Other: _____**

This authorization will remain in effect until patient revokes this authorization in writing by sending written notification to my office address. However, your revocation will not be effective to the extent I have taken action in reliance on the authorization or if this authorization was obtained as a condition of insurance and the insurer has a legal right to contest a claim.

Name of Patient:_____ DOB:_____

Name of Guardian (if applicable): _____

Signature: _____ Date:_____