

FLOWER MOUND FAMILY PHYSICIANS

2609 SAGEBRUSH DR. SUITE 101

FLOWER MOUND, TX 75028

OFFICE #972-539-4875 FAX#972-539-3488

Patient Name: _____ Date of Birth: _____

This medical release form will authorize Flower Mound Family Physicians to

Release Medical Records

Obtain Medical Records

from any listed provider or facility a copy, summary, or narrative of my medical records as indicated. At this time I am requesting that the following:

Complete Record

Records of care concerning the following condition(s): _____

Other(Specify) _____

Name of Physician/Medical Facility: _____

Address: _____

Phone: _____ Fax: _____

Reason for Request (must be completed):

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral mental health services and treatment for alcohol or drug abuse.

Yes, I consent to the release of this information

No, I do not consent to the release of this information

I understand that the information released is for the specific purpose stated above. Any other use of this information without written consent of the patient is prohibited. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.

I understand that you will provide this information within 15 business days from receipt of this request and you charge a fee for preparing and furnishing this information.

In accordance with Texas law, the fee for preparing and furnishing medical records is \$25.00 for the first 20 pages and .50 per page for each page thereafter plus the cost of postage.

Signed: _____ Date _____