Medical Records Release Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

I do hereby consent and authorize Regenerative Wellness Solutions & its providers to release copies of my medical records.

Patient Name: _____ Medical Record No. _____

Address: _____ Apt. _____

City/State/Zip Code: _____

Date of Birth _____ Social Security Number (Last Four Only) XXX-XX-_____

RECORDS REQUESTED FROM REGENERATIVE WELLNESS SOLUTIONS

Name of Person or Facility: _____

Practice Address: 1617 Park Place Ave Ste. 110 Fort Worth, Texas 76110

E-mail: <info@regenerativewellnesssolutions.com> Phone: (817) 717-7294 Fax: (817) 717-9388

RECORDS TO USE OR DISCLOSE TO

Name of Person or Facility: _____

Practice Address: _____ Ste. _____

City/State/Zip: _____

Phone: _____Fax: _____

E-mail: _____

Please select all the specific documents that apply to your request:

- ☐ Clinic Notes
- ☐ Progress Notes
- ☐ H&P
- ☐ Discharge Summary
- ☐ Radiology Reports/Lab Reports/Pathology Reports
- ☐ Nurses Notes
- ☐ Operative Reports
- ☐ EKG/EEG/EMG
- ☐ ER/Urgent Care Reports
- ☐ Doctor Consults

- [ ] Physician Orders
- [ ] Medication/Allergy List
- [ ] Other: _____

Patient Signature (or Legal Representative) : _____Date: _____

Patient Name (or Legal Representative): _____ (Please Print)