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Diplomates of the Board of Internal Medicine,

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MEDICAL RECORDS RELEASE FORM

By signing this form, I authorize you to release confidential health information about

me, by releasing a copy of my medical records, or a summary or narrative of my health information, to the person(s) on entity listed below. I hereby authorize release the following from the health records of Pt.Name_____ DOB_____SSN__ Information to be released: Copy of completed records ____ History and Physical/Consultation reports ____ Laboratory, Radiology, PFT, ECHO, Venous Doppler Information related to HIV testing results Other Information to be released to: Name: Address: City/State/ZIP: _____ Phone: Fax: Information to be released for the purpose of: Medical Care Legal Insurance Other (detail) Date: Signature: _____ Patient or Representative Relationship Date: Witness

I understand that you will provide this information within 15 Day from receipt of request and that a fee of preparing and furnishing this information may be charged according to rulling set forth by the Texas State Board of Medical Examiners. I understand that the information released for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.