MEDICAL RECORDS **Authorization for the Release of Medical Information**

RELEASE TO: Dr. Flavia Thomas

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#1102
Missouri City, Texas 77489

Phone: (346) 433- 1579
Fax: (833) 579 - 2806

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1. PATIENT INFORMATION:

Patient Name: **DOB:** **Phone Number:**

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2. ACTION:

*** New Care Provider - Please give the above named care provider access to my medical records.

RELEASE INFORMATION FROM: Who do you want to request medical records from -

Name: _____ **Phone:** _____

Address: _____ **Fax:** _____

City: _____ **State:** _____ **Zip Code:** _____

3. INFORMATION TO BE RELEASED:

***Review options and check appropriate box(es):

☐ Clinical Notes ☐ Radiology Reports ☐ Specialist Reports ☐ Pathology Reports ☐ Lab results ☐ Other Diagnostic Test Results (Cardiac, Pulmonary Function, Neurological Testing, etc.) ☐ Other (Please Specify) **:**_____

4. THE PURPOSE OR NEED FOR DISCLOSURE:

*** Continued Care etc: _____

5. AUTHORIZATION:

Permission is hereby granted to_____ to release medical information to the individual/organization as identified above. Note: submission of this form authorizes future disclosures to the same individual and/or entity within one year from date of signature.

Patient/Authorized Signature: _____

Print Name:_____ **Date:** _____