Houston Endocrine Center

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Medical Records Release

I authorize ______________________________ to (circle one) release to:/receive from:

Doctor or Organization ____________________ Phone # ____________________ Fax # ____________________

Address ________________________________ ____________________ ____ __________
Street City State Zip

Patient's Name ________________________________ Date of Birth ____________________

Information/Copies to Be Released (Check All That Apply)

- ☐ Emergency Room
- ☐ Radiology Reports
- ☐ Lab Work
- ☐ H&P
- ☐ Drug/Alcohol information
- ☐ Pathology Report
- ☐ Billing records
- ☐ Consultations
- ☐ Discharge Summary
- ☐ Psychiatric Information
- ☐ All Records
- ☐ Other (please explain) ______________________________

Purpose of Release of Information:

- ☐ Continued Care
- ☐ Attorney/Litigation
- ☐ Insurance
- ☐ Disability Service
- ☐ Other

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that even this authorization shall expire 1 year from the date of my signature, unless specified in writing here:

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I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider the release information may no longer be protected by federal and state privacy regulations. TO THE PARTY RECEIVING THIS INFORMATION; this information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, a federal regulation (42 CFR, Part 2) prohibits you from making any further disclosures of it without specific written consent of the person whom it pertains, other information is no sufficient for this purpose. FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 PART 2

____ ____________________
Signature of Patient or Legally Authorized Representative Date

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Printed Name of Patient or Legally Authorized Representative