

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION



2900 E 29th St. Suite 100, Bryan, TX 77802 (P) 979-436-0447 (F) 877-601-5854

Privacy Notice: The information on this form together with any attachments is the property of Texas A&M Health (TAMH). State Law requires that you be informed that you are entitled to: (1) request notification of the information collected about you by use of this form (with a few exceptions as provided by law); (2) receive and review that information; and (3) have the information corrected at no charge to you.

Instructions: Please note that each section of this form must be completed in its entirety. Failure to specify (including dates) will delay the processing of your request. Allow 14 Business Days for Processing.

PATIENT	Patient Last Name	Patient First Name	Patient Middle Name	Date of Birth
RELEASED FROM	Name/Organization		Email Address	Phone
	Address		City, State, Zip Code	Fax
Information may be: Mailed Faxed Phoned Emailed Picked up by Name: _____				
RELEASED TO	Name/Organization		Email Address	Phone
	Address		City, State, Zip Code	Fax
PURPOSE	Records are to be released for the following purpose(s): (Select all that apply)			
	Medical Care Insurance	Personal Legal/Attorney	Other (specify): _____	
INFORMATION TO RELEASE	Indicate types of records to be released : (Select all that apply)			
	Entire Record	Appointment History	Radiology Reports	
	Chart Summary	Progress Notes	Radiology Images	
	Immunizations	Lab Reports	Operative Reports	
Other (specify): _____				
PATIENT/ PARENT/LEGAL GUARDIAN AUTHORIZATION	Unless otherwise revoked, the Authorization will expire 60 days from the date it is signed or, if specified, on the following date: _____.			
	This Authorization may be revoked at any time. In order to revoke the Authorization the individual/parent/legal guardian must submit a revocation request in writing to the Medical Records Department at the address below.			
	I, the undersigned, hereby authorize Texas A&M Health (TAMH) to use and/or disclose information from my (or given relationship) _____ medical or financial record as specified above. This authorization includes the use and/or disclosure of information concerning HIV testing, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or mental health conditions to the above mentioned entity(ies). I agree not to hold TAMH, its employees, agents, officers, members, students, and participating health care providers responsible for lost, stolen, or otherwise misplaced medical information that cannot be reproduced.			
	Signature of Patient: _____ Date: _____			
	By signing the below, I verify that I have legal right(s) to obtain the requested medical information for the patient listed above. Signature: _____ Date: _____ Parent/Legal Guardian/Spouse/Patient Representative			
OFFICE USE ONLY	Request completed by: (PRINT NAME)		Signature	Date/Time
	Released by: (PRINT NAME)		Signature	Date/Time
Witness (If released via telephone)		Signature	Date/Time	