# HIPAA Medical Records Release Form

## Print or Type

Name:_____
Last First Middle

Social Security # _____-_____-_____ Date of Birth_____ Phone_____

**Please give name and address of medical facility you are authorizing your medical records be released from:**

Physician/Clinic: West Texas Retina Consultants

Address: 5441 Health Center Dr, Abilene, TX 79606

Phone: 325-673-9806 Fax: 325-673-9809

**I authorize my medical records be released to:**

Name:_____

Address:_____

Phone:_____ Fax:_____

**Check all records to be released**

☐ Mental Health ☐ Drug/Alcohol use/abuse ☐ Labs/Test Results

☐ HIV (AIDES) tests/results ☐ All Medical Records ☐ Follow Up Exams

☐ Billing ☐ Other (specify)_____

**Purpose of records being released:**

☐ Continuity of care ☐ Personal copy ☐ Insurance claim

☐ Legal claim ☐ Disability claim ☐ Other

This authorization is in effect from _____ to _____. Upon conclusion of this time, this authorization is automatically revoked.

I understand that:

- I may refuse to sign this authorization and that my refusal has no impact on receiving treatment
- I can inspect or copy any information disclosed under this agreement
- My signing the document is voluntary
- I can revoke authorization at any time, except to the extent that the practice has acted upon this authorization and revocation must be in writing
- I can receive a copy of this authorization
- Federal laws will not cover information once it is released

Patient/Legal Guardian Signature:_____ Date:_____

Witness:_____ Date:_____

Identification of requestor of patient information is verified: Yes ☐ No ☐ Type_____