WOODLANDS INTERNISTS

17191 St. Lukes Way, Suite 201
The Woodlands, TX 77384
phone: 936-273-2016
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Medical Release for Records

To disclose and/or receive copies of information to the following Physician:

Physician Name: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Phone: ____________________ Fax: ____________________

Including the diagnosis and records of any treatment or examination rendered to me during the period of time __________ (date) to __________ (date).

______________________________ ______________

Patients Name (print) **Date of Birth**

Specifically, the following reports will be included:

_______ X-rays _______ X-ray Reports _______ Laboratory/Pathology Reports ______ Progress Notes

______ Other (specify) ____________________

______ (initials) I ___ **DO** or ___ **DO NOT** consent to release of information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol and/or drug abuse diagnosis, prognosis and treatment and/or HIV(AIDS) testing and/or results or such disclosure shall be limited to the following specific types of information: ______________________________

Purpose of disclosure: ______ **Medical Care** _____ **Attorney** ____ **Insurance** _____ **Other**

This authorization shall be valid for 120 days from the date of signature. The patient can revoke the authorization in writing at any time prior to the expiration date. The patient agrees that a photocopy of this authorization may be considered valid. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer to protect. I hereby release and hold harmless the above named facility and its parent company from all liability and damage resulting from the lawful release of my Protected Health Information.

______________________________ ______________

Signature of Patient or Authorized legal representative **Date**

____________________ ____________________

Relationship to Patient **Witness Signature and Date**