1301 W 38TH STREET, SUITE 601
AUSTIN, TEXAS 78705
PH# (512)454-5171 FAX# (512)454-0704

MEDICAL RECORDS RELEASE

I hereby authorize Capital Medical Clinic to provide a copy, summary or narrative of my medical records or otherwise release confidential information from the records of:

PATIENT NAME_______________________________DOB__________SSN_______________PHONE#__________
PLEASE PRINT

PLEASE INDICATE SPECIFIC RECORDS NEEDED BELOW:

Please give specific dates of records needed or list records needed concerning specific conditions:

____

These records may include but are not limited to treatment for psychological or psychiatric conditions, drug abuse and/or alcoholism, sickle cell anemia, hepatitis, STD's, acquired immunodeficiency syndrome (AIDS) or tests for or infection with human immunodeficiency virus (HIV) **unless specifically limited here**:

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__ ____

PLEASE CHECK ONE OF THE FOLLOWING:

_____**Please mail protected health information to OR email to address given to download:**

____
Name

____
Street

____
City State Zip

Email address: ____

OR_____Person authorized to pick up records:____

Please state the reason you are requesting records **(required by Texas Occupational Code):

____

******FOR QUALITY ASSURANCE PURPOSES******
IF CHANGING PHYSICIANS, PLEASE GIVE REASON FOR CHANGE

Capital Medical Clinic, its staff and physicians are released from legal responsibility or liability for the Release of the above information to the extent indicated and authorized herein.

I understand that this consent may be REVOKED in writing at any time except to the extent that disclosure has already occurred in reliance on this consent. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law. I further understand that this **consent will expire (90) ninety days from the date signed** and that a fee for preparing and furnishing this information may be charged. I have read and understand all information contained herein.

A photocopy of this release is as valid as the original.

Signed____Date_____________________
Patient or person legally authorized to consent on patient's behalf

____
Relationship to patient if legally authorized for patient

____ Date_____________________
Witness

Revised 3-11-2020