CapitalMedicalClinic
Serving Austin since 1934

OUTSIDE PHYSICIAN
MEDICAL RECORD RELEASE
HIPAA COMPLIANT
(IF FEE IS REQUIRED, PLEASE CONTACT PATIENT DIRECTLY)

PATIENT NAME:_____ DOB_____

OBTAIN MEDICAL RECORDS:

FROM:_____ **TO: DR:**_____

_____ **CAPITAL MEDICAL CLINIC, LLP**

_____ **1301 W. 38TH ST, SUITE 601**_____ **PH: 512-454-5171**

_____ **AUSTIN, TEXAS 78705**_____ **FAX:512-454-0704**

RECORDS DATED FROM _____TO_____ONLY **OR**

RECORDS CONCERNING THE FOLLOWING CONDITIONS ONLY:

_____

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**:

_____
_____

THE PURPOSE FOR THIS DISCLOSURE (REQUIRED BY TEXAS OCCUPATIONAL CODE)**
IS:_____

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

DO NOT RETURN THIS FORM TO CAPITAL MEDICAL. PLEASE SEND IT TO YOUR PREVIOUS PHYSICIAN.

Revised 12/13/2012