



**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

1004 W 32nd St, Suite 400 **PH: 512-454-5171**

Fax #: _____ **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

Witness Date _____

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