RECORDS RELEASE

REQUEST FOR RELEASE OF MEDICAL RECORDS

NAME: _____
(Please Print)

SSN: _____ **Date of Birth** _____

TO: _____
(Physician's name)

ADDRESS: _____
(Street Name & Number) (City) (State) (Zip Code)

☐ **All Medical Records** ☐ **Records From:** _____ **To** _____

☐ **Other** _____

_____

_____

I hereby authorize _____ to release my medical records or copies of such and request these records be sent to:

CareFirst Medical Associates and Pain Rehabilitation, PA
403 State Hwy. 110 N.
Whitehouse, TX 75791
P 903.839.1000
F 903.839.4000

The Federal Government now restricts this office and its attending providers from discussing your health information and/or condition with other family members or persons, unless you give your written permission to do so. By my signature below, I grant CareFirst Medical Associates permission to discuss my protected medical information with the following individuals (check only those persons you want to have access to your medical information):

☐ Spouse / Significant Other: (Name)_____

☐ Leave test results and/or appointment times on answering machine or leave it with your spouse or family member.

☐ Release medical records/information to these other physicians who are providing medical care:

_____ _____

_____ _____

Signature:_____Date:_____