**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

2900 E 29th St. Suite 100, Bryan, TX 77802 (P) 979-436-0447 (**F**) **877-601-5854**

**Privacy Notice:** The information on this form together with any attachments is the property of Texas A&M Health (TAMH). State Law requires that you be informed that you are entitled to: (1) request notification of the information collected about you by use of this form (with a few exceptions as provided by law); (2) receive and review that information; and (3) have the information corrected at no charge to you.

# Instructions: Please note that each section of this form must be completed in its entirely. Failure to specify (including dates) will delay the processing of your request. Allow 14 Business Days for Processing.



**PATIENT**

**Patient Last Name**

**Patient First Name Patient Middle Name**

**Date of Birth**

**RELEASED**

**Name/Organization Email Address Phone**

**FROM**

**Address**

**City, State, Zip Code**

**Fax**

**Information may be: Mailed Faxed Phoned Emailed Picked up by Name:**

**Name/Organization Email Address Phone**

**RELEASED TO**

**Address City, State, Zip Code**

**Fax**

**Records are to be released for the following purpose(s): (Select all that apply)**

**PURPOSE**

**Medical Care Insurance**

**Personal Legal/Attorney**

**Other (specify):**

**Indicate types of records to be released : (Select all that apply)**

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**INFORMATION TO**

**RELEASE**

**Entire Record Chart Summary Immunizations**

**Appointment History Progress Notes**

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**Lab Reports**

**Radiology Reports Radiology Images Operative Reports**

**Other (specify):**

Unless otherwise revoked, the Authorization will expire 60 days from the date it is signed or, if specified, on the following date: .

This Authorization may be revoked at any time. In order to revoke the Authorization the individual/parent/legal guardian must submit a revocation request in writing to the Medical Records Department at the address below.

**PATIENT/ PARENT/LEGAL GUARDIAN AUTHORIZATION**

I, the undersigned, hereby authorize Texas A&M Health (TAMH) to use and/or disclose information from my (or given relationship) medical or financial record as specified above. This authorization includes the use and/ or disclosure of information concerning HIV testing, any drug or alcohol abuse, drug-related conditions, alcoholism, and/ or mental health conditions to the above mentioned entity(ies). I agree not to hold TAMH, its employees, agents, officers, members, students, and participating health care providers responsible for lost, stolen, or otherwise misplaced medical information that cannot be reproduced.

Signature of Patient: Date:

By signing the below, I verify that I have legal right(s) to obtain the requested medical information for the patient listed above.

Signature: Date:

Parent/Legal Guardian/Spouse/Patient Representative

# Request completed by: (PRINT NAME) Signature Date/Time

**OFFICE USE ONLY**

**Released by: (PRINT NAME)**

**Signature Date/Time**

**Witness (If released via telephone) Signature Date/Time**