ASAP - URGENT: Patient's Authorization to Release Medical Records

PATIENT INFORMATION

NAME:	
DAY PHONE NUMBER:	
BIRTH DATE:	
IDENTIFICATION OR SOCIAL SEC. #:	

HOLDER OF MEDICAL RECORDS

Name of clinic and/or physician:			
Street:			
City, state, zip code:			
Phone/ Fax:		Fax:	
Optional: Approx. dates of treatment:	Beginning:	Continuing until:	present

INFORMATION TO BE RELEASED

- **Copy of complete health records including chart notes, lab and imaging reports**: history and physical
- Lab results: please send all lab and imaging reports
- Imaging studies: Radiographs, MRI, US, CT, etc.: please send all lab and imaging reports

INFORMATION IS TO BE RELEASED AND SENT TO:

Dr. Alex Vasquez D.C., N.D.
7211 Regency Square, Suite 200
Houston, TX 77036

Phone: (713) 840-9355

Fax: 713 840-9468

PATIENT CONSENT AND AUTHORIZATION TO RELEASE MEDICAL RECORDS

1. This authorization is valid for ninety (90) days from the date signed. I understand this consent can be revoked by me at anytime before disclosure has occurred.
2. Unless specifically excluded, this authorization includes release of specially protected records—such as referral to, diagnosis of, and/or treatment for substance abuse, mental health conditions, and sexually transmitted diseases such as HIV.
3. I understand that records of my healthcare are protected under state and federal regulations regarding confidentiality and cannot be released or discussed without my written consent unless otherwise provided for or allowed by these regulations.

Patient/ guardian AUTHORIZING SIGNATURE:	
TODAY'S DATE:	

MINOR'S CONSENT

- This applies to persons aged 13 to 18 for records pertaining to substance abuse and/or mental health records, and to persons aged 14 to 18 for records pertaining to sexually transmitted diseases, including HIV.

Minor's SIGNATURE:	
TODAY'S DATE:	