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### Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

**HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agents of AIDS with the rest of my medical records. Initial: \_\_\_\_\_ Date: \_\_\_\_\_**

Limitations on the information you may release subject to this Release Form are as follows:

\_\_\_\_\_

Release my protected health information to:

Records requested from:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Street: \_\_\_\_\_

Street: \_\_\_\_\_

City/ST/Zip: \_\_\_\_\_

City/ST/Zip: \_\_\_\_\_

The reasons or purposes for this release of information are as follows:

Treatment

\_\_\_\_\_

Patient Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

DOB: \_\_\_\_\_

SS#: \_\_\_\_\_

Date: \_\_\_\_\_

**I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas Board of Medical Examiners.**

