# AMARILLO FAMILY PHYSICIANS CLINIC, P.A.

1215 COULTER, SUITE 100
AMARILLO TX 79106
806-359-4701

## Medical Records Release

**FROM:**_____

_____
Address

_____
City State Zip

_____
Phone Number/ Fax Number

_____
Patient Last Name First Middle

_____
Address

_____
City State Zip

_____
Phone Number

_____ _____
Date of Birth Social Security #

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 below.

**Your initials are required to release the following information:**

____ Mental Health Records (excluding psychotherapy notes)
____ Drug, Alcohol, or Substance Abuse Records
____ HIV/AIDS Test Results/Treatments
____ Genetic Information (Including Genetic Test Results)

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

_____

**Release my protected health information to the following person(s)/entity:**

Name:_____

Street: _____

City: _____ State: _____ Zip: _____

**Reason for release of information are as follows:**

❑ Continued patient care ❑ Attorney/Legal Purposes ❑ Employment
❑ Insurance Claim/Application ❑ Personal use ❑ Other _____

I understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 180 days after the date of my signature unless otherwise specified.

I further 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 State Board of Medical Examiners.

_____ _____
**Patient Signature** [or parent, guardian or legal representative] Date