Authorization to Release Health Care Information

Patient's Name: _____ Date of Birth: _____

Previous Name: _____

Best Contact Number: _____

I request and authorize Dr. _____ (address) _____

(phone) _____ / (fax) _____ to release a copy of medical records of the above named patient to:

Grace Gynecology & Wellness / Graceful Wellness
1005 W Ralph Hall Parkway, Suite 107 & 130
Rockwall, TX 75032
Telephone: (469) 769 – 1961
Fax: (469) 769 – 1905

The request and authorization applies to:

___ All healthcare information.

___ Healthcare information relating to the following treatment, condition, or dates of treatment: _____

_____

___ Other: _____

The reasons / purpose for this release of information are: _____

_____

_____

I understand that my express consent is **required** to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information related to such diagnosis, testing, or treatment.

_____ _____

Signature of Patient or Patient's Authorized Representative Date Signed

Relationship or status if signed by anyone other than patient: _____
(Example: parent, legal guardian, personal representative, etc.)

This authorization expires **180 days** after the date it is signed.