Diabetes and Endocrine Associates of Tarrant County, LLP

MEDICAL RECORDS RELEASE

Requesting Medical Records **FROM**:	Requesting Medical Records be sent **TO**:
Doctor/Hospital	Doctor/Hospital
Address	Address
City, State, Zip Code	City, State, Zip Code
Phone # Fax #	Phone # Fax #

Patient Information:

Patient Name _____ Date of Birth _____

Address _____ City, State, Zip _____ Phone Number _____

Release the following records:

___ Complete medical record

___ Specific records: _____

___ Other: _____

By signing this form, I authorize you to release confidential health information about myself, by releasing a copy of my medical records of my protected health information to the person or entity listed above. I understand that information in my health records may include information relating to STD, AIDS, HIV, behavioral healthcare, alcohol and/or drug abuse, and that my signature releases such information. I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and forwarding this information may be charged. This authorization for release of medical records is valid for 90 days from my signature and date below.

Patient Signature _____ Patient's Printed Name _____ Date _____