Authorization to Release
Health Information

Patient Name: ____ Chart #: ____________________

Date of Birth: __________________________________ SSN: _______________________________

Home Phone #: ____________________________ Work Phone #: _______________________________

I request and authorize:

Name: ____

Address: ____

City, State & Zip: ____

To release health information of the patient named above to:

Name: ____

Address: ____

City, State & Zip: ____

_____ Progress Notes _____ Immunization Records _____ Lab

_____ X-Ray _____ EKG _____ Entire Medical Record

_____ Other (specify): ____

I understand my express consent is required to release any health information related to testing, diagnosis, and/or drug and/or alcohol use. **Initial:** ________________________

If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted disease, pregnancy, psychiatric disorder/mental health, or drug and/or alcohol use, you are specifically authorized to release all health information relating to such diagnosis, testing, or treatment. **Initial:** __________________________

The purpose for releasing this information:

_____ Further Medical Care _____ 3rd Party Reimbursement

_____ Other (specify): ____

Signature of Patient or Legal Representative: ____

Relationship to Patient: ____________________________________ Date: ________________________

Witness: ____ Date: ________________________

FAMILY MEDICAL GROUP, 2101 GALLERIA OAKS, TEXARKANA TX 75503
PHONE (903) 791-9120 FAX (903) 791-9132

FAMILY MEDICAL GROUP, 5212 W. 7TH STREET, TEXARKANA TX 75501
PHONE (903) 831-6848 FAX (903) 223-7089