

## 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 agent of AIDS with the rest of my medical records. **Initial:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please list each child's name and date of birth on a separate line AND list any limitations or restrictions to this release.

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

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

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

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

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

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**Patient signature (or parent, guardian or legal representative):**

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**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 State Board of Medical Examiners.