Willow Bend Family Medicine, P.A.
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Plano, TX 75093
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Authorization to Release Medical Records/Information

I authorize a copy of the medical records/information by paper or on a flash drive for:

PRINT NAME: _____ SSN: _____ DOB: _____

RELEASE TO:
NAME: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE/FAX: _____

RELEASE FROM:
NAME: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE/FAX: _____

By initialing the spaces below, I specifically authorize the release of the following medical records/information, it such records exist:

( ) All records
( ) Immunization records
( ) Radiology/MRI/CT/Ultrasound reports
( ) Laboratory/pathology reports
( ) Records during a specific time frame of _____ to _____ (dates)
( ) Other _____

NOTE: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, mental health information, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

I understand once the records have been disclosed my health information, it may no longer be protected by federal and/or state privacy laws. I further understand that this authorization is voluntary. My refusal to sign will not affect my ability to obtain treatment, payment, eligibility for benefits unless allowed by law. I understand this authorization may be revoked in writing at any time. Unless otherwise revoked, this authorization will expire 1 (one) year from date of signature.

_____ _____
Patient signature or person authorized by law Date

COST FOR MEDICAL RECORDS/INFORMATION: For paper records/information; $25.00 for first 20 pages and $0.50 per page thereafter and $35.00 for flash drive. Payment method: Credit Card / Cash