

Authorization for Release of Medical Information**Medical Records Release Form**

Sammy Lerma III, M.D. P.A.
 1109 Church Street, Bastrop, TX 78602
 Phone: (512) 321-3311 Fax: (512) 321-2611
 www.drssammylerma.com

Patient Full Name (PRINT) _____ DOB _____

Telephone Number: _____

Mail to:

The patient A doctor/hospital A third party (insurance company/attorney)

Name : _____

Mailing address: _____

Phone #: _____ Fax: _____

In what format would you like the records? Paper copy Electronic copy Combination of paper/electronic

Dates of treatment: All dates OR Specific dates: from _____ to _____

Please check specific information requested:

All Medical Records

OR

Abstract of record (Office Notes, Procedures, & Test Results Only)

OR CHECK SPECIFIC RECORDS

Discharge Summary
 History & Physical
 Hospital/ER visit
 Images
 Immunizations

Lab reports
 Medication List
 Medical/Surgical History
 Occupational Health Rec
 Pathology reports

Physical Therapy Notes
 Physician Office Visits
 Progress Notes
 Radiology (x-ray) reports
 Other: (specify) _____

The purpose of the disclosure: ("Request of the Individual" is sufficient for patient-initiated releases)

Request of the Individual _____	Change of Doctor _____	Legal Investigation _____
Referral to Specialist _____	Insurance _____	Other: (specify) _____
Continuing Care _____	Workers' Comp _____	

CONDITIONS and NOTIFICATIONS:

State law allows a patient to obtain a copy of his/her records or ask that a copy be sent to other parties. Our office shall furnish the information within 15 business days after the date of the receipt of the request of records and payment of fees for furnishing the information directly to the patient. Patients will receive an estimate of the charges before making copies; the fee we charge is cost-based. Fees must be paid in advance of record release. There will be no charge for records sent directly to a provider for continuity of the patient's care.

I hereby authorize the use or disclosure of the personal health information as described above. I also understand that if the individual or organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by federal privacy regulations and, therefore, may be subject to redisclosure.

Signature of Patient/Personal Representative: _____ Date: _____

PRINT Name of Personal Representative: _____

Relationship of Representative to Patient: _____