Office Use Only - Account Number: _____________ Revised July 2018

Physical Address: 1109 Church Street, Bastrop, TX 78602
Phone: (512) 321-3311 Fax: (512) 321-2611

Mailing Address: **PO Box 664, Bastrop, TX 78602**
website: *www.drsammylerma.com*

Authorization for Release of Medical Information
Medical Records Release Form

Patient Full Name (PRINT)____ Date of Birth_________________
Telephone Number: ____

SELECT ONE:
☐ **Pick up** records for patient (self) **OR** ☐ **Fax electronic copy** to:
☐ A doctor/hospital ☐ A third party (insurance company/attorney)

*Name of doctor/hospital/third party:*____

Mailing address: ____

Phone #: _______________________________*Fax:*____

PLEASE CHECK SPECIFIC INFORMATION REQUESTED:

Dates of treatment: ☐ All dates OR ☐ Specific dates: from _________________________ to _______________________

☐ All Medical Records **OR**	☐ Abstract of record (Office Notes, Procedures, & Test Results Only)

OR CHECK SPECIFIC RECORDS

☐ Discharge Summary	☐ Lab reports	☐ Physical Therapy Notes
☐ History & Physical	☐ Medication List	☐ Physician Office Visits
☐ Hospital/ER visit	☐ Surgical History	☐ Progress Notes
☐ Images	☐ Occupational Health Rec	☐ Radiology (x-ray) reports
☐ Immunizations	☐ Pathology 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.

PRINT Patient Name ____ Date of Birth _____________

Signature of Patient or/Guardian ____________________________________ Date ________________

Relationship to Patient (Self, Mother, Father, care provider, etc.)___________________________________