Patient Medical Records Release Form

Patient Name: _____
DOB: _____
SS #: _____

I hereby authorize the use or disclosure of information:

To: **DR. GILMORE, M.D.** P#(214) 361-5285 fax(214)946-7844
10740 N.CENTRAL EXPWY SUITE#120 DALLAS, TX 75231
From: _____

For the purpose of: _____

Please release the following:

____ All records

OR CHECK BELOW SPECIFIC RECORDS

____ Problem List	____ X-Ray/Imaging Reports	____ List of Allergies
____ Progress Notes	____ X-Ray Films	____ Genetic Testing Info
____ History/Physical Exam	____ Lab Results	____ Immunization List
____ Medication List	____ EKG Reports	

____ Other (Specify) _____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

____YES, I consent to the release of this information.
____NO, I do not consent to the release of this information.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition. (_____). If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

COMPLETE ONLY IF INFORMATION RELEASED DIRECTLY TO THE PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold _____ liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of Patient or Legal Representative Date

Relationship of Patient (if Legal Representative) Date