



**MEDICAL RECORDS RELEASE AUTHORIZATION FORM**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Release Records From:** Conroe Family Medicine/Kelsey Seybold  
690 S Loop 336 West, STE 222, Conroe, TX 77304  
Phone: 936-756-6661 Fax: 936-756-6681

**Release Records To: Conroe Family Physicians**  
Dr. Chapman, Dr. Hinds-Campa, Dr. Sheih  
690 S. Loop 336 West, STE 140, Conroe, Texas 77304  
Phone: 936-523-7041 Fax: 936-271-2557

The health information you may release subject to this authorization is as follows (✓):

\_\_\_\_\_ All medical records    \_\_\_\_\_ Labs    \_\_\_\_\_ Radiology    \_\_\_\_\_ Consult Notes

\_\_\_\_\_ From service date(s): \_\_\_\_\_ to \_\_\_\_\_

**HIV/AIDS:** I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agents of AIDS with the rest of my medical records.    **Initial:** \_\_\_\_\_    **Date:** \_\_\_\_\_

The purpose for this release of information is for patient care and treatment. This authorization shall be in force and effective for 60 DAYS from the date below. By signing this form, I authorize you to use and disclose the protected health information. I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to Conroe Family Physicians at the address below. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date