Conroe Family PHYSICIANS
Together Achieving Better Health

MEDICAL RECORDS RELEASE AUTHORIZATION FORM

Patient Name:_____ DOB:_____

Release Records **From**: _____

_____

_____

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: 936-523-7042**

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