



**BONE &
JOINT
CLINIC**
OF HOUSTON P.A.

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MEDICAL RECORDS RELEASE FORM

Patient Name: _____
Address: _____
City/State/Zip: _____
Phone: _____
SSN / Birth Date : _____ / _____

By signing this form, I authorize Bone & Joint Clinic of Houston to release the following confidential health information about me* (check all applicable):

- All records Other (please explain) _____
- Operative reports _____
- Test results (radiology, EMG's, laboratory) _____
- Specific request for CD copies of X-rays or MRI (additional charges apply)

* HIV/AIDS: I consent to the release of any positive or negative tests result from AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.
Initial: _____ Date: _____

These records are for ALL services provided or for the following date(s) only: ____ - ____ - ____ / ____ - ____ - ____
Please release records listed above to:

Name: _____
Address: _____
City/State/Zip: _____
Phone/Fax: _____ / _____

The information will be used/ for each of the following purpose(s): (mark all that apply)

- Personal Worker's Comp
- Legal/Attorney Other (please explain) _____
- Insurance _____
- Disability _____

This Authorization shall remain valid from the date it was signed, unless otherwise revoked in writing.

I understand that when my medical information is released pursuant to a valid authorization, federal privacy laws may no longer protect it. I also understand that this is a voluntary authorization and I have the right to revoke the authorization in writing. The refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law.

Signature of patient (or patient's personal representative) Date

Printed name of patient representative Relationship to patient

I understand you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

Fax Cover Sheet

CAUTION: CONTAINS CONFIDENTIAL HEALTH CARE INFORMATION

To: **Medical Records
Bone & Joint Clinic of Houston**

From:

Fax: 713-790-7500

Phone:

Date:

Fax:

Pages: (including fax cover sheet)

Re:

Comments:

Confidentiality Notice

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