

CONSENT FOR RELEASE OF INFORMATION

PATIENT NAME

DATE OF BIRTH

REASON FOR RELEASE RECORDS: ____ Transferring to New Provider ____ Copies to Specialist

(INITIAL) _____ General Authorization
(INITIAL) _____ Specific Request of Drug and Alcohol Abuse Patient
(INITIAL) _____ Specific Request of HIV Diagnostic Testing Patient
(INITIAL) _____ Specific Request of Psychiatric Patient

Records released will cover the **LAST TWO YEARS** of pertinent information consisting of:
Office Notes, Immunization Record, Test Results, Consult and Hospital Notes.

OR:

Specific Information: _____

SEND TO: NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ Zip Code _____
Phone # _____

Payment is required prior to release of records

2017 Medical Records Reproduction Fee Schedule - ACT 26

Pages 1 - 20 ----- \$ 1.48 per page
Pages 21 - 60 ----- \$ 1.10per page
Pages 61+ ----- \$.37 per page
+ ACTUAL POSTAGE COST

- > I have read and understand the above consent and hereby release Dallas Family Practice, L.L.C. and it's employees from any and all legal responsibilities in connection with this act.
- > I understand this consent is subject to written revocation only, at any time except to the extent that the person who is to make the disclosure has already acted in reliance on it.
- > This consent will expire in 60 days from the date of signature if not revoked earlier.

Patient Signature

Date of Patient Signature

Signature of Responsible Party

Date of Responsible Party's Signature

Witness Signature

Date of Witness Signature