350 Westpark Way Suite. 123
Euless, Texas 76040
(817) 267-3065 Office | (817) 545-9097 Fax

AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS

Patient Name: _____ Date of Birth: ____/____/____
Current Address: _____ Current Phone #: (_____)_____-_____

RELEASE MEDICAL RECORDS FROM:
Name of Facility: _____
Address: _____
Phone#: (_____)_____-_____
Fax#: (_____)_____-_____

DISCLOSE MEDICAL RECORDS TO:
Ivy Children's Clinic
350 Westpark Way Ste.123 Euless, Texas 76040
Phone#: (817) 267-3065
Fax#: (817) 545-9097

I am requesting medical records for the following date range:
From: ____/____/____ To: ____/____/____

Please send my requested information by:
√ Fax: **(817)545-9097** ☐ Mail: _____ ☐ Email: _____

I authorize the following types of information to be released:

☐ ALL medical records	☐ Labs/ Pathology/ Imaging	☐ Hospital Records
☐ Immunizations/Vaccines	☐ Specialist Consultations	☐ Operative Notes
☐ History/Physical Exams	☐ Emergency Room Report	☐ Discharge Summary
☐ Labs/Pathology/Imaging	☐ Photos	☐ Other:

Purpose of Disclosure: (please specify)

☐ Transfer of care	☐ Continuity of Treatment
☐ Personal use	☐ Other:

Expiration Date: ____/____/____
*If left blank, this authorization will expire one year from the date signed.

I recognize that the health information disclosed may contain information that is privileged and protected by law and I specifically consent to the disclosure of suck information. I understand I have the right to inspect or copy the information to be used/disclosed as permitted by federal law. All records obtained will be used solely for professional purposes. This authorization may be revoked by me in writing at any time and must be submitted to the releasing party. A written cancellation in the future will have no effect on any records that may have been released prior to the receipt of the written cancellation. Information released may be subject to re-disclosure by the recipient. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected. I understand that a copy of this release is as valid as the original and I may also receive a copy of this form after I sign it. In consideration of this consent, I hereby release the above parties from any and all liability arising there from.

Printed Name of Patient/ Parent/ Legal Guardian: _____

Signature of Patient/ Parent/ Legal Guardian: _____ Date: ____/____/____

Relationship to patient: _____

Notice: There may be a cost for producing medical records in accordance with State and Federal Law