**Trumed Family Clinic**

2801 Osler Dr Suite 120, Grand Prairie, TX 75051

Main (214)677-0208 · Fax (214)677-0230 · [www.trumedfamilyclinic.com](http://www.trumedfamilyclinic.com)

**CONSENT TO RELEASE / OBTAIN MEDICAL RECORDS**

DATE: \_\_\_\_\_\_\_\_\_\_\_\_

PATIENT: FIRST \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LAST \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH (MM/DD/YYYY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Trumed Family Clinic

\_\_\_\_\_\_\_\_\_ To RELEASE copies of my medical records to:

\_\_\_\_\_\_\_\_\_ To RECEIVE copies of my medical records from:

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the release information may no longer be protected by federal and state privacy regulations.

The following information is requested and may be released:

All Records \_\_ Medical Summary \_\_

Progress Notes \_\_ Lab Data \_\_

Medications \_\_ X-ray reports \_\_

Operative Records \_\_ EKG Reports \_\_

By checking ALL records, I hereby give my express consent to release all medical records regarding my treatment, including genetic information and testing, family history, psychological treatment, drug abuse, alcohol use, human immunodeficiency virus (HIV) infections including acquired immunodeficiency syndrome (AIDS) or test for HIV, or sexually transmitted diseases.

\*Please specify description of purpose of the use and/or disclosure

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I understand that this authorization will expire by the law 180 days from the date from the date of this authorization unless I otherwise specify. I further understand that I may revoke this authorization at any time by notifying Trumed Family Clinic in writing. I understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before receipt of the written revocation. I understand that copies of records are subject to a $25.00 minimum fee.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of Patient or representative) (Date) (MM/DD/YYYY)

(\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Daytime phone number)