AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN THIS FORM.

I, _____, hereby voluntarily authorize the disclosure of information from my health record.
Name of Patient

Patient information:

Patient Name: _____ DOB: _____

Address: _____

Information Requested:

_____

_____

_____

Purpose of Release:

_____

_____

The information is to be provided to:

Compassion Dental of Harlingen
2401 Ed Carey Dr. Suite B, Harlingen, Tx 78550
(956) 428-4434
Please email x-rays to Compassiondentalofharlignen@gmail.com

_____ _____
Patient's Signature or Patient's Representative Date

_____ _____
Printer Name o Patient's Representative Relationship to Patient

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose.

PLEASE MAKE A COPY OF THIS RELEASE FOR YOUR RECORDS.

Under HIPPA with a patient's written request, records must be provided within 30 days of a request.
Under House Bill 300 Texas Law with a patient's written request, records must be provided within 15 days of a request.

HIPPA Authorization for Release of Medical Records
This for does not constitute legal advice and covers federal, not state law.