LEXARECORDS
Medical Records Management Company
99 Trophy Club Dr , Trophy Club Texas 76262
Phone: 817-421-4700 Fax: 817-421-4766

*There may be a fee to copy your records.
We will contact you if there is.

Consent/Authorization for Release of Information – MUST BE FILLED OUT IN ITS ENTIRETY

I hereby authorize the use or disclosure of my individual identifiable health information as described below. I understand that this authorization is voluntary and the patient does not have to sign this authorization as a condition of receiving treatment from the medical facility. I understand that information that is disclosed in accordance with this authorization may be disclosed further by the recipient, and that the information may no longer be protected by federal or state privacy regulations regarding protected health information.

Patient Name: _____ **Phone:** _____

Date of Birth: _____ **EMAIL:**_____

MEDICAL FACILITY RELEASING RECORDS

Doctor/Hospital Name: _____

Address: _____

_____

Phone: _____

PERSON/ORGANIZATION RECEIVING RECORDS:

Person/Organization Name:_____

Address: _____

_____

Phone: _____ **Fax:** _____

COVERING THE PERIOD (S) OF TREATMENT: _____ to _____

SPECIFIC RECORDS REQUESTED: (circle one or more) ***All Health Information; Physician's Orders; Progress Notes; Pathology Reports; History/Physical Exam; Discharge Summary; Billing Information; Medications; Operation Reports; Diagnostic Test Reports; Radiology Reports and Images; Lab Results; Consultation Reports; EKG/Cardiology Reports; Other*** _____

REASON FOR DISCLOSURE: (circle one) ***Treatment; Personal Use; Billing or Claims; Insurance; Legal Purposes; Disability Determination; School; Employment; Other:*** _____

Release Mental Health Records? (yes or no) _____

Release Genetic Information? (yes or no) _____

Release Substance Abuse Information? (yes or no) _____

Release HIV/AIDS Tests, Results, Treatment (yes or no) _____

1. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation.
2. I understand that my records are protected under state and federal law. I understand that specific information to be disclosed may include history of drug or alcohol abuse, mental health treatment, AIDS, and all other medical information.
3. I understand and agree that my medical records will be maintained in a computerized and/or paper medical information system and that records may be transmitted electronically via fax to medical providers or by US mail to patients.
4. A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment 9 (See, e.g., TX Fam. Code 32.003).
5. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or one year from the date of this authorization; or the following specific date (optional) or event: Month _____Day_____Year_____

_____ _____

Signature of patient or patient's legally authorized representative Date

Printed name and Relationship to patient if not signed by the patient: _____