

MEDICAL RECORD RELEASE FORM

Family Medicine MMC
5616 E Sam Houston Pkwy N
Houston, TX 77015
Telephone: 281-452-2299
Fax: 281-452-2298

Patient Name

Date of Birth

I hereby authorize the below listed entity to release medical information to Dr. Maria Mejia, MD, with Family Medicine MMC.

Name: _____ Telephone#: _____

Address: _____ Fax#: _____

Medical Information Requested:

- All Records
- Specific Records from _____ to _____
- Immunizations & Physical Examinations
- Radiology Films {X-Ray, Mammography, Ultrasound, CT, MRI, etc.}

Signature of Patient or Legal Guardian

Date

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.