Patient Consent for Disclosure of Information

I authorize the release of my protected health information to the following person(s):

NAME:_____

ADDRESS:_____

PHONE:_____

RELATION TO PATIENT:_____

Limitations on the information you may release subject to this Release Form are as follow:_____

_____

_____

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records.

Initial:_____ **Date:**_____

( ) **I DO NOT AUTHORIZE THE RELEASE OF MY INFORMATION TO ANYONE**

_____

Patient Signature (or Parent, Guardian, or Legal Represenative) **Date**

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) listed above

Medical Records Release Form

Medical Record Release Requested From:

Doctor's Office: _____

Address: _____

Phone Number: _____

Fax Number: _____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

Bridlewood Family Healthcare
3400 Long Prairie Road Suite 200
Flower Mound, TX 75022
972-899-6300
972-899-6020 (Fax)

Limitations on the information you may release subject to this Release Form are as follows: _____

_____

The reason or purposes for this release of information are as follows: _____

_____

_____

Patient Name: _____ **DOB:** _____

_____

Signature of Patient (Parent, Guardian, or Legal Represenative): **Date:**

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

[ ] **I DO NOT WISH TO HAVE MY RECORDS RELEASED**