Patient Consent of Disclosure of Information

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

Name: _____

Address: _____

Phone: _____

Relationship to Patient: _____

OR

{ } I DO NOT AUTHORIZE THE RELEASE OF MY INFORMATION TO ANYONE

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

_____

_____

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

Initials: _____ Date: _____

_____

Patient Signature (or Parent, Guardian, or Legal Representative) 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 protective health information, to the person(s) listed above.

Medical Records Release Form

Medical Records 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
P) 972-899-6300
F) 972-899-6020

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

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

Patient Name: _____ DOB: _____

_____
Signature of Patient (Parent, Guardian, or Legal Representative) Date

I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing the 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 RELEASE