AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Release to Total Family Care:

12350 Westheimer Rd. Suite G
Houston, TX 77077
Phone 281.496.1199 **Fax 713.481.8795**

Patient Name: ____________________________________ Date of Birth: __________________________

Social Security #: ____

Information to Be Released – Covering the Below Periods of Health Care

From (date):______________________________ To (date): _____________________________________

_____ Complete health record
_____ Complete billing record
_____ Consultation reports
_____ Discharge summary
_____ Other (please be specific) ____

____ History and physical exam
____ Lab results
____ X-ray reports
____ Pathology reports

Purpose of Request

_____ Treatment or Consultation
_____ At the request of the patient

Records are to be Released From:

Name: ____

Address: ____

Drugs, Alcohol Abuse, Psychiatric, and HIV/AIDS Records Release

I understand if my medical or billing records or psychotherapy notes contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to this release.

Drug/Alcohol Abuse *Circle One* Yes No **Psychiatric** *Circle One* Yes No

HIV/AIDS *Circle One* Yes No

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Signature of Patient or Legal Guardian Date