Release of Medical Records

Patient Name: _____

Date of Birth: _____

I hereby authorize: _____
_____
_____
_____
Phone: _____
Fax #: _____

to release all medical records and pertinent information, including diagnosis, or medical history, treatment of any physical or mental condition, drug or alcohol abuse history or treatment. I also authorize the release of test results or information relating to HIV or confirmed diagnosis of treatment for any sexually transmitted disease as required by law in my state. Medical records are to be sent to:

North Cypress Internal Medicine & Wellness
Kelly M. Englund, M.D.
21216 NORTHWEST FREEWAY # 420
CYPRESS, TX 77429
Phone: (281) 807-5300

FOR LESS THAN 40 PAGES ONLY MAY FAX TO 281-807-5311

THIS INFORMATION IS TO BE USED FOR PURPOSES OF
PRIMARY CARE

I HEREBY RELEASE YOU, YOUR PHYSICIANS AND EMPLOYEES FROM LIABILITY FOR THIS AUTHORIZATION REQUEST.

AUTHORIZATION IS VALID FOR 90 DAYS FROM DATE OF SIGNATURE.

_____ _____
PATIENT/LEGAL GUARDIAN SIGNATURE TODAY'S DATE

_____ _____
WITNESS SIGNATURE TODAY'S DATE