Pelican Medical Specialists PLLC
Phone (972) 674-9910
Fax (972) 666-5166

RELEASE OF INFORMATION FOR MEDICAL RECORD

PATIENT NAME: _____
PATIENT ADDRESS: _____
PATIENT DATE OF BIRTH: _____
PATIENT DATE OF SERVICE: _____
PATIENT PHONE #: _____
PATIENT SSN: _____
I hereby authorize _____ to release information and forward to: (provider)
_____
Please check type of information to be released:
Please check the reason the above information is released:
_____
_____

Complete Medical Record	Lab Results	X-Ray Results/Film
Notes/Results for DOS:	Consultation Reports	Billing Records
Immunizations	Other, please specify	
Transfer to another physician	Legality Purposes	Specialist opinion
Personal File	Disability Benefits	Other, please specify

I understand that the specific information to be disclosed may include history of DRUG AND ALCOHOL ABUSE, or MENTAL HEALTH TREATMENT, or information concerning communicable diseases such as HUMAN IMMUNODEFICIENCY VIRUS (HIV) and ACQUIRED IMMUNE DEFICIENCY SYNDROME(AIDS), and laboratory test results, treatment progress or any other such related information.
I understand that my treatment or payment for services will not be denied should I elect not to sign the authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for per-employment purposes. However, no protected information will be release without a signature. Also, I understand that information disclosed in accordance with this authorization may be subject to re-disclosure by the recipient and no longer protected by the Standards of Privacy and Individually Identifiable Health Information (45 CFR parts 160 & 164).
I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it. The authorization will expire 180 days from the date of my signature on or otherwise specified by date, event or condition as follows:
_____
I further authorize that a photocopy of this authorization is acceptable as an original. I understand I may be charged a processing fee for copies of my medical records according to Texas Hospital Licensing Law.

Signature of Patient or Legal Representative Date Relationship to Patient

_____ _____

Date of Request: __/__ /__
Record copying cost: $ _____.00 _____ Cash _____ Check # _____ C.C