# CENTER FOR WELLNESS AND HEALING

**2002 Binz Street Houston, Texas 77004 713 520 9611 713 520 9618 Fax**

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## *REQUEST FOR RELEASE OF RECORDS*

**(COMPLETE BY PATIENT OR GUARDIAN)**

Patient Name_____SS#_____DOB:_____

Address_____Tel#_____

Physician/Facility_____ **Fax #_____**
**Ph #_____**

**(OFFICE USE ONLY)**
**I hereby authorize _____to release**
**Facility Name**

**The Medical Records of_____ for the treatment dates**
**Patient Name**

**From _____To_____ for the following purposes:**

**_____Medical _____Legal _____Insurance _____Other(Specify)_____**

_____ Complete Record (Yes/No) _____ Include HIV _____ Include Chemical Dependency

**Records concerning the following:**
_____ Imaging/Radiology Results_____
_____ Lab Studies _____
_____ Cardiac Studies _____
_____ Emergency Room _____
_____ Chart Documents _____ H & P _____ MD Orders _____ MD Progress Notes
_____ Summaries/Reports _____ Operative _____Admissions _____ Discharge
_____ Other _____

I, the undersigned, have read the above and authorize the staff of above-named facility to disclose such information as herein contained. I have the right to revoke the authorization in writing at any time except yo the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I thereby release and hold harmless the above-named facility and its parent company from all liability and damages resulting from the lawful release of my Protected Health Information.

| _____ | _____ | _____ |
|---|---|---|
| Date | Patient/Guardian Signature | Authority/Relationship to Patient |

This authorization is valid until 180 days after it is signed unless it provides otherwise; not to exceed 24 months, or unless it is revoked, and covers only treatment(s) for the dates specified above.