AUTHORIZATION TO RELEASE HEALTH INFORMATION
PLEASE COMPLETE ENTIRE FORM

Name of Provider/Facility: I hereby authorize ______________________________ to release health records information on:

Patient Name:__________________________________ Date Of Birth:_____________ Social Security #___________________
Patient Phone Number 1______________________________ 2.______________________________
Primary Secondary

For Healthcare Covering the Periods from ________________To:________________ **OR** _____ all dates
For the purpose(s)of: ____

PLEASE RELEASE RECORDS TO:

Name of Provider/Facility **Village Family Practice**
Address: 9055 Katy Freeway, Suite 200
Houston, TX 77024 ph: 713- 461-2915 fax- 713-461-5307

I ☐ do ☐ do not (check applicable box) authorize this information to be faxed. If yes:
Fax Number: _______________________ Name of Person to Receive Fax_______________________

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
___**Yes,** I consent to the release of this information. ___ **No**, I do not consent to the release of this information.

REVOCATION: I understand that this authorization maybe revoked in writing at any time, except the extent that actions have already been taken in response to this authorization for the purposes stated above.

Unless otherwise indicated, this authorization will expire in ninety (90) days from date of signature. The physician and employees are released from any legal responsibility or liability for disclosure to the above information to the extent indicated and authorized herein.

I understand that there may be a fee for preparing and furnishing this information

____ ___________________________ ______________
Signature of Patient or Legal Representative **Relationship to Patient** **Date**

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:
I understand that my medical records may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold __________________________ liable for any misinterpretation of the information in my medical record as result of not consulting my physician for the correct interpretation.

__________________________________ ___________________________ __________________
Signature of Patient or Legal Representative Relationship to Patient Date

Preparation Fee $25.00 for the first 20 pages $0.50 per additional page **Copy OF Billing Records $25.00**

TO BE COMPLETED BY VILLAGE FAMILY PRATICE STAFF ONLY!

Date request completed __________________ # pages copied ___________ Charges $ _____________

Send out by _______________________________ *Method* _____Mailed _____Faxed ______ Picked up