Medical Records Release

This form is to be used for obtaining your medical records for your own use.
Please speak with your clinic to send your medical records to another physician.

When filling out the Medical Records Release form, please note the following costs:

$25 for the first 20 pages
+ $0.50 per page for each page past 20.

Please mail or fax your completed form to your clinic or to the Medical Records Department at:

Houston Family Physicians, PA
Medical Records Department
4126 Southwest Freeway
Suite 600C
Houston, TX 77027
Fax 832-369-7355

If you have any questions or concerns, please call us at 832-487-8644.

Thank you,

Medical Records Department
Houston Family Physicians, PA

Release of Confidential Information Consent

I,

Patient Name (please print)

Address *City* *State* *Zip*

Date of Birth *Social Security Number* *Phone Number*

I hereby freely, voluntarily, and without coercion, authorize Houston Family Physicians, P.A. to release a copy of my medical information to:

Name: Address City/State/Zip Phone Number

Reasons records are being requested:

- □ Insurance claim
- □ Review by attorney
- □ Disability
- □ Care by physician
- □ Continuing care
- □ Other (Please specify:

I release Houston Family Physicians, P.A., its Physicians, Directors, Administrators, Employees and Associates from all legal responsibility or liability resulting form the release of such information and I waive, on behalf of myself, my heirs, assigns and any persons who many have an interest in the matter, all provisions of law relating to the disclosure of such information. I understand that I may revoke this consent at any time. It must be revoked in writing.

Person (or Legal Guardian) Signature *Date*

Witness Signature *Date*

Houston Family Physicians PA
8303 Southwest Freeway Ste. 125 Houston, TX 77074
Telephone: 713.522.7002 Fax: 713.528.3351