AUTHORIZATION TO RELEASE MEDICAL INFORMATION
North Richland Hills Location

This form will authorize the following party to release medical records as indicated below:

RECORDS REQUESTED FROM:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

_____ ***By initialing here, you are authorizing the release of your entire chart including the following information:***

HIV Information
Sexually Transmitted Disease (STD) Information
Mental Health Information
Substance Abuse Records
Tobacco/Alcohol Use

_____ Dates of service from _____ to _____

_____ Records of care concerning the following condition(s):

_____

RECORDS TO BE SENT TO:

North Hills Family Practice – North Hills Location
4351 Booth Calloway, Suite #101
North Richland Hills, TX 76180
Office: 817-284-1165 Fax: 817-590-9721

I understand that my records **WILL NOT** include the individual items listed above unless I initial it is okay to copy/send this information.

Signed: _____
(Patient or person legally authorized to consent on patient's behalf)

_____
Print name of patient Relationship to patient

_____
Patient's Date of Birth

Date: _____