7692 Eldorado Parkway
McKinney, Texas 75070
972.562.8388 (Phone)
972.540.2219 (Fax)

Medical Records Release Authorization

Patient's Full Name: ____________________________________ DOB: __________________________________
Phone #: ____ SS#: __________________________________
Address: ____

I authorize records: (please select one):
( ) To be released **TO** McKinney Family Medicine from ____

Address: ____

Phone: _____________________________ Fax: ___________________________

( ) To be released **FROM** McKinney Family Medicine to ____

Address: ____

Phone: _____________________________ Fax: ___________________________

To release the following:
_____ any and all medical records _____ operative report
_____ recent PAP results _____ recent lab results
_____ office visit for ____________ (date) _____ other ____________________

The purpose of this disclosure is for ***treatment/payment/healthcare operations*** unless specified here:
____

This authorization gives McKinney Family Medicine permission to request your medical records from any health care provider that you have received treatment from as specified above for the duration that you have direct treatment relationship with McKinney Family Medicine. McKinney Family Medicine is authorized to furnish information even though the confidentiality of the information may be protected by Federal or State laws and regulations. **This includes any and alcohol and/or drug treatment records or psychiatric records and any information related to HIV or sexually transmitted disease testing or results that are in the record, unless specified above.** McKinney Family Medicine is released and discharged from any liability, and the undersigned will hold McKinney Family McKinney Family Medicine harmless for complying with this information.

I understand the following:
- ✓ I am not required to sign this authorization.
- ✓ I may revoke this authorization at any time by presenting my written revocation to McKinney Family Medicine, 7692 Eldorado Pkwy., McKinney, TX 75070.
- ✓ The revocation will not apply to information that has already been used or released under this authorization.
- ✓ Physician's office has the right under Texas State Law to require payment up front for reasonable costs of copying and mailing before furnishing the medical records.

____________________________________ ____________________________________
Signature of Patient or Legal Representative Printed Name of Patient or Legal Representative

____________________________________ ____________________________________
Relationship to patient or Legal Representative Date

____ ____

Witness Date

NOTICE TO PERSON OR AGENCY RECEIVING THIS INFORMATION: *This information has been disclosed to you from records whose confidentiality is protected. Laws and Regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient.*