Authorization for Release of Patient Information

I hereby authorize the release of my medical records **to the following physician**:

Carolyn W. Quist, D.O, PA
1425 8th Ave., Suite 101
Fort Worth, TX 76104

Phone: 817-926-1313
Fax: 817-926-7434

To be Released From the Following Physician, Clinic, or Hospital:

Name: ____

Address:____

Phone Number:_______________________________ Fax Number:_______________________________

Patient's Name:
SS#
DOB

We are Requesting the Following Records:

[ ] Progress Notes
[ ] Lab Results
[ ] Diagnostic Imaging Results
[ ] ER Notes & Diagnostic Reports
[ ] Other____
[ ] History and Physical
[ ] Immunization Record

Reason for Request:

[ ] Continued Care
[ ] Referral
[ ] Patient's Request
[ ] Other____
[ ] Disability Claim
[ ] Legal Purposes

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a processing fee for copies of my medical records ($25.00 for the first 20 pages plus $.50 per page over 20) according to Texas Health Information Management Act (TXHIMA)

This authorization will expire one hundred and eighty (180) days from the date of my signature unless I revoke this authorization in writing prior to that time.

____ ______________________________
Patient or Legal Guardian Signature Date

____ ______________________________
Witness Signature Date