

Family Healthcare Affiliates PLLC
800 Riverwood Court, Suite 105
Conroe, Texas 77304
Phone 936-760-4454/ Fax 936-760-4415

Patient Name: _____ Date: _____

Address: _____ DOB: _____

Receive Records From:

Release Records To:

IKP Family Medicine

11026 TX-242

Conroe, TX 77385

Please send a copy of my records as indicated for date(s) of treatment: _____

_____ Operative Reports _____ Lab Reports _____ H&P
_____ X-ray Reports _____ Immunization Records _____ Other

Purpose for releasing medical information: **Continuation of Care**

Signature of Patient, Parent or Legal Guardian

Witness

I understand that my express consent is required to release any health information relating to testing, diagnosis and/ or treatment of alcohol or drug related medical problems, and this special consent also will apply to HIV/AIDS related diagnosis, sexually transmitted diseases and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal laws. Federal regulations (42 C.F.R. Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith.

Signature of Patient, Parent or Legal Guardian

Witness

Date

Permission to FAX records for medical emergency? ____yes ____no

This authorization expires ninety (90) days from the date of signature.