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O: (979) 968-8493

1253 N Von Minden
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O: (361) 865-3302
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230 W North Main
Flatonia, TX 78941

Giddings
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Giddings, TX 78942

CONSENT TO RELEASE MEDICAL INFORMATION

Patient Name: ____ Date of Birth: ___________________

PHYSICIAN RELEASING RECORDS:

Name: _______________________________________

Address: _____________________________________

City, State, & ZIP: ______________________________

Phone: ______________________________________

Fax: ____

PHYSICIAN/PERSON TO RECEIVE RECORDS:

Name: La Grange | Flatonia | Giddings Family Health Centers

Address: 1253 N Von Minden

City, State, & ZIP: La Grange, TX 78945

Phone: 979-968-8493

Fax: 979-968-6388

MEDICAL INFORMATION TO BE SENT:

____ MEDICAL RECORD, INCLUDING information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

____ ENTIRE MEDICAL RECORD, EXCLUDING information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted disease and HIV/AIDS.

____ RECORD OF CARE FROM ________ TO ________, INCLUDING information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted diseases and HIV/AIDS.

____ RECORD OF CARE FROM ________ TO ________, EXCLUDING information related to the treatment for substance abuse or dependency; psychiatric or mental health treatment; information related to testing or treatment of sexually transmitted disease and HIV/AIDS.

This applies to all information in my medical record protected under the regulations in 42 Code of Federal Regulations, Part 2. I authorize medical information to be released as indicated above. I understand this release is effective until _______________ or 180 days after date of signature, but that I may revoke my consent at any time by providing written consent to the above-named party.

____ ___________________________

Patient or Patient's Legal Guardian Date

____ ___________________________

Witness Date