



# La Grange | Giddings Family Health Centers

La Grange  
O: (979) 968-8493  
1253 N Von Minden  
La Grange, TX 78945

MAIN FAX LINE: 979-968-6388

Giddings  
O: (979)542-7400  
598 Cactus St  
Giddings, TX 78942

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## CONSENT TO RELEASE MEDICAL INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### PHYSICIAN RELEASING RECORDS:

### PHYSICIAN/PERSON TO RECEIVE RECORDS:

Name: \_\_\_\_\_

Name: La Grange | Giddings Family Health Centers

Address: \_\_\_\_\_

Address: 1253 N Von Minden

City, State, & ZIP: \_\_\_\_\_

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

Phone: \_\_\_\_\_

Phone: 979-968-8493

Fax: \_\_\_\_\_

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