La Grange | Flatonia | Giddings
Family Health Centers

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

Flatonia
O: (361) 865-3302
MAIN FAX LINE: 979-968-6388
230 W North Main
Flatonia, TX 78941

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