

AUTHORIZATION FOR DISCLOSURE
OF CONFIDENTIAL INFORMATION
(Medical Records Release Form)

Name of Patient: _____

Date of Birth: _____ Social Security Number: _____ - _____ - _____

This authorizes: **Northwest Diagnostic Clinic @ e-MDs, P.A.**
500 West Whitestone Blvd.
Cedar Park, Texas 78613
Phone 512-250-3900/Fax 512-401-6203

to provide a copy, summary, or narrative of my medical records (as indicated by the checkmark(s) below) or otherwise release confidential information. I agree that a photocopy of this authorization may be considered valid.

- Complete record
- Records of care from the following dates: _____ to _____
- Records concerning the following conditions: _____
- _____ Other, _____ please specify: _____
- Confer with person(s) listed below orally about my medical information:

HIV / AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, anti-bodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.
Patient Signature: _____ **Date:** _____

Release the information to:

Phone: _____ Fax: _____

The reasons or purposes for this release of information are as follows:

- Medical Care
- Insurance
- Attorney
- Change of Medical Provider
- Specialist
- Change of Medical Provider due to Insurance
- _____ Other, _____ please specify: _____

Patient Signature: _____ **Date:** _____

I understand that you will provide this information within 30 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.