Medical Records Release Form
(PLEASE PRINT LEGIBLY)

PATIENT NAME:_____ DOB:_____

Address:_____ Apt:_____

City:_____ State:_____ Zip:_____

Would you like your records: ☐ Mailed ☐ Faxed ☐ Pick up in Person

I authorize Evexias Medical Centers to: ☐ SELF ☐ Obtain records FROM ☐ Release records TO

PRACTITIONER NAME:_____

Practice Name:_____

Address:_____ Suite:_____

City:_____ State:_____ Zip:_____

Office:_____ Fax:_____ Contact Person:_____

IF SENDING RECORDS TO EVEXIAS, PLEASE FAX TO:

Rockwall Clinic 469-402-1969

Southlake Clinic 817-328-8379

SPECIFIC INFORMATION AUTHORIZED (select one or more as appropriate):

- □ Assessments
- □ Diagnostic Impression
- □ Discharge Summary
- □ Lab Test Results
- □ Latest Mammogram Results
- □ Latest Pap Results
- □ Progress Notes
- □ Treatment Plans
- □ Treatment Summary
- □ Other (*please explain*): _____

PLEASE NOTE: The release of HIV-related information requires additional information.

USAGE PREFERENCE (select only ONE):

□ **One-Time Use/Disclosure**: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified. **My authorization will expire when the requested information has been sent/received.**

□ **Periodic Use/Disclosure**: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document. **My authorization will expire: When I am no longer receiving services from Evexias Medical Centers and/or one year after this date.**

_____ _____

Patient Signature (or Legal Representative) **Date**

_____ _____

If under 18, Legal Representative Name (PRINTED) **Relationship to Patient**

This medical records release form has been reviewed by:

_____ _____ _____

Practitioner Name (PRINT) **Signature** **Date**