MEDICAL RECORDS RELEASE AUTHORIZATION FORM

Patient Name:____ DOB:___________________

Release Records **From**: _______________________________________

____

____

Release Records **To**:

College Park Medicine
17191 St. Luke's Way, Ste 200
The Woodlands, TX 77384

Phone: 936-271-2555 **Fax: 936-271-2557**

William McDonough, M.D.● Duyen Wolken, PA ● Abigail Striblea,FNP ●

The health information you may release subject to this authorization is as follows (✓):

_____All medical records _____Labs _____Radiology _____Consult Notes

_____From service date(s):________________ to ________________

HIV/AIDS: I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agents of AIDS with the rest of my medical records. **Initial:** ________________ **Date:** ______________

The purpose for this release of information is for patient care and treatment. This authorization shall be in force and effective for 60 DAYS from the date below. By signing this form, I authorize you to use and disclose the protected health information. I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to College Park Medicine at the address below. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

_______________________________________ _________________________

Signature of Patient or Personal Representative Date