PREMIER PHYSICIANS
2501 W. Illinois, Ste. C
Midland, TX   79701
432 686-6600   FAX   432 682-2284

MEDICAL RECORD REQUEST FORM

In accordance with the Health Insurance Portability and Accountability Act of 1996 you are giving permission to release Protected Health Information as defined herein. Understanding that this authorization may be re-disclosed to additional parties and will no longer be protected by HIPAA. Further understanding that this may be revoked at any time by contacting the below Medical Records Officer, and that such a revocation does not apply to the extent that persons authorized to use or disclose the health information have already acted in reliance on this authorization.

Name: _____   **Date:** _____

Date of Birth: _____ **SSN:** _____ **Phone:** _____

I hereby request and authorize: (Doctor's Name) _____

(Clinic Name) _____

To release my personal medical information to:
      (Doctor's or Person's Name) _____
      (Address, City
      State. ZIP) _____

Purpose of the Release: _____

Treatment Dates to be Released: _____
As required by HIPAA any release of Protected Health Information may only be strictly "minimum necessary" except when defined as to date and substance. (Complete Chart is Unacceptable when not defined by date etc.)

Information Requested in the above time period: (please check requested areas)

___Physician Office Notes	___Pathology Reports	___Psychiatric Notes *(see restrictions for release)*
___Lab Reports	___Surgical Reports	___Billing/Collections
___X-Ray Reports	___Consult Notes	___Other: _____
___Other Diagnostic Studies	___Physical Therapy Notes	_____

> **HIV / AIDS:** I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:** _____   **Date:** _____

In requesting the medical records I understand there maybe fees for preparing and furnishing the information, per TEXAS State Board of Medical Examiners regulations as follows: $25.00 for pages 1-20 and $0.50 per page for each page there after. This will include postage to send if necessary. The request will be completed within 15 business days following full payment of required amount for each record.
    I understand this information release is for the specific purpose above and may not be provided in whole or in part to any other agency, organization or person. I understand this correspondence and records from other health care providers will not be released. I may revoke this authorization at any time and this authorization expires 180 days from the date of signature unless otherwise specified.

_____   _____
Patient Signature or Legal Representative   **Date**

_____   _____
Relationship to Patient   **Witness**
                                    Fee Paid _____
                                      Records Sent _____ **Date** _____
_____
Authorization withdrawn—Signature & Date   **Initial Personnel** _____