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Wichita Falls, TX 76309
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Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me. Please release a copy of my medical records or a summary or narrative of my protected health information to the person(s) or entity listed below.

*Patient Name: _____

*Social Security Number: _____ *DOB: _____

Records to be sent from the following facility:

*Physician's Name/Clinic: _____

*Address: _____ *City, State, Zip: _____

*Phone: _____ *Fax: _____

Limitations:

☐ Complete record

☐ Records of care from the following dates: _____ to _____

☐ Records concerning the following conditions: _____

☐ Confer orally with person(s) or entity listed below about my medical information.

☐ Other, please specify: _____

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

***Release my protected health information to the following person(s) or entities:**

☐ Kell West Family Practice Clinic
4412 Kell Boulevard
Wichita Falls, TX 76309
940.696.0011 Fax: 940.696.2248

☐ Other: _____
Address: _____
_____
Phone: _____ Fax: _____

*The reason or purpose for this release of information is _____

I understand you will provide this information within fifteen 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 Board of Medical Examiners.

*Patient Signature (or parent, guardian, or legal representative): _____ Date: _____

*MUST BE COMPLETED IN FULL.