

RECORDS RELEASE

REQUEST FOR RELEASE OF MEDICAL RECORDS

NAME: _____ (Please Print)

SSN: _____ Date of Birth _____

TO: _____ (Physician's name)

ADDRESS: _____ (Street Name & Number) (City) (State) (Zip Code)

All Medical Records Records From: _____ To _____

Other _____

I hereby authorize _____ to release my medical records or copies of such and request these records be sent to:

CareFirst Medical Associates and Pain Rehabilitation, PA
403 State Hwy. 110 N.
Whitehouse, TX 75791
P 903.839.1000
F 903.839.4000

The Federal Government now restricts this office and its attending providers from discussing your health information and/or condition with other family members or persons, unless you give your written permission to do so. By my signature below, I grant CareFirst Medical Associates permission to discuss my protected medical information with the following individuals (check only those persons you want to have access to your medical information):

Spouse / Significant Other: (Name) _____

Leave test results and/or appointment times on answering machine or leave it with your spouse or family member.

Release medical records/information to these other physicians who are providing medical care:

Signature: _____ Date: _____