Medical Records Release Form

I authorize you to release my confidential health record to the entity listed below

Pearl Family Practice, P.A.
950 West University Ave Suite 104
Georgetown,TX 76826
(o) 512-869-8500
Please Mail Medical Records. Do not fax them. Thank you.
www.pearlfamilypractice.com
drk@pearlfamilypractice.com

Medical Records to be sent from the following facitlity or clinic:
Clinic Name:____________________________ **Doctor's name**_________________________
Office phone____________________________ **Office fax**____________________________

Office
Address:____
____

Patient's name____
Date of birth _____/______/_______ **Phone #(____)**____________________________
Patient's home address:____
____

The purpose of this release of information is:______________________________________

Please circle one:

1. **Complete record**
2. **Records from dates**___________**to** ____________
3. **Records regarding following conditions only**__________________________________
4. **other**____

I also consent to the release of any positive or negative HIV or AIDS infection with my medical records. Initial _____________**Date**_____________

____

_____________________________   _________________________
Patient's signature   **Date:**