



HOPE CLINIC
delivering hope & health

Medical Records Release

Patient Name: _____ DOB: _____

RELEASE TO: _____ Phone number: _____

RELEASE FROM: Hope Clinic, 103 E Lamar St. McKinney, TX 75069 (p) 469.712.4246 (f) 469.545.1992

INFORMATION TO BE RELEASED: (Check all applicable)

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> All Information | <input type="checkbox"/> All Progress Notes | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> X-ray Reports |
| <input type="checkbox"/> Electrocardiogram (ECG) | <input type="checkbox"/> Allergy Records | <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Latest Labs | <input type="checkbox"/> Surgical Reports | <input type="checkbox"/> Imaging (past 2 yrs) |
| <input type="checkbox"/> Last Office Visit Progress Notes | | | |

SPECIAL AUTHORIZATION: Check applicable box(es) and sign immediately below.

By signing below, I am authorizing the office to release any and all information regarding:

- ☐ Alcohol ☐ Drugs ☐ Mental Health ☐ Sexually Transmitted Diseases ☐ HIV ☐ AIDS

Note: If this release pertains to alcohol, drug, or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Signature: _____ Date: _____

4. **RECORDS FROM THE TIME PERIOD:** ____/____/____ through ____/____/____

5. **PURPOSE OF DISCLOSURE:** (Check applicable purpose)

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Continued Medical Care | <input type="checkbox"/> Payment of Insurance Claim | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Personal | <input type="checkbox"/> Workers' Compensation Claim | <input type="checkbox"/> Other: _____ |

6. I understand that this authorization shall be valid for five years. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

7. The requestor may be provided with a copy of this authorization.

Patient/Guardian Signature: _____ Date: _____
