

Medical Records Release Form

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

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:** _____

Limitations on the information you may release subject to this Release Form are as follows:

Release my protected health information to the following person(s)/entity:

Name: Crescent Family Medicine, P.A. Maria A. Flaquer, M.D.

Street: 820 S. Alma Dr Suite 130

City: Allen **State:** TX **Zip:** 75013

The reasons or purposes for this release of information are as follows:

Primary Care

Patient Name: _____ **DOB:** _____

Patient signature (or parent, guardian or legal representative):

Date:

I understand that you will provide this information within 15 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 State Board of Medical Examiners.

Fax Cover Sheet

CAUTION: CONTAINS CONFIDENTIAL HEALTH CARE INFORMATION

To: From: Crescent Family Medicine. Maria A.
Flaquer, M.D.

Fax: Phone: (972)747-0777

Date: Fax: (214)383-4559

Pages:

Re:

Comments:

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