WOODLANDS
MEDICAL SPECIALISTS

Release for Outside Facility Disclosure

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

First Name _____ Last Name _____

Date of Birth_____ Social Security #_____

I hereby authorize Woodlands Medical Specialists to disclose the following specific information from my health record to:

Name of Physician: _____

Name of Practice: _____

Office Number: _____

Fax Number: _____

INFORMATION TO BE DISCLOSED (PLEASE INITIAL ALL THAT APPLY)

Entire Health Record ____ Lab Results ____ Radiology/Imaging Reports _____ Operative Report _____

Mammogram Report ____ Physician Consults ____ History/Physical ____ Other _____

REASON FOR DISCLOSURE (PLEASE INITIAL ALL THAT APPLY)

Continued Care ____ Insurance Claim _____ Legal Purposes _____

Personal Use ____ Other _____

I understand if I do not authorize the release of my entire health record, only a limited health record is provided per patient request.

I understand I may revoke this authorization in writing at any time, except to the extent that action has already been taken; forms are available. Woodlands Medical Specialists are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.

I understand it *could take 7 to 10 business days* for this request to be processed. I further understand that I am entitled to a copy of this authorization.

Signature of Patient: _____ Date: _____

Signature of Representative: _____ Date: _____

Witness: _____ Date: _____