

AUTHORIZATION RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of information from the medical record of:

Patient Name: _____

Date of Birth: _____

Social Security #: _____

Phone Numbers: _____

RELEASED FROM:

**The Texas Hip and Knee Center, LLP
750 Eighth Ave # 400 Ft Worth 76104
(817) 877-3432 P (817) 877-0207 F**

RELEASED TO:

This request is effective one year from the date signed, unless revoked in writing.

This medical record release will include all medical records contained in the file of the patient including but not limited to: progress notes, lab reports, xrays reports, other diagnostic reports, as well as any references that might have been made concerning mental health, drug/alcohol use, and HIV/Aids.

****PURPOSE OR NEED FOR DISCLOSURE: (must be completed)**

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire one year after date of my signature unless otherwise specified.

Signature of Patient or Legal Representative

Date

Relationship to Patient

****COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:**

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Texas Hip and Knee Center, LLP or it's physicians liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of Patient or Legal Representative

Relationship to Patient