FLOWER MOUND
FAMILY PHYSICIANS

Flower Mound Family Physicians
2609 Sagebrush Dr. Suite 101
Flower Mound, TX 75028
Phone: 972-539-4875
Fax: 972-539-3488

RECORD RELEASE AUTHORIZATION

Patient Name: _____ DOB: _____

This medical release form will authorize Flower Mound Family Physicians to

_____ Release Medical Records _____ Obtain Medical Records

from any listed provider or facility, a copy, summary, or narrative of my medical records as indicated.
At this time, I am requesting the following:

_____ Complete Record

Records of care concerning the following condition(s): _____

Other (Specify): _____

Name of Physician/Medical Facility: _____

Address: _____

Phone: _____ Fax: _____

Reason For Request (must be completed):
I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral mental health services and treatment for alcohol or drug abuse.

_____ Yes, I consent to the release of this information.

_____ No, I do not consent to the release of this information.

I understand that the information released is for the specific purpose above. Any other use of this information without written consent of the patient is prohibited. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released as a response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.
I understand that you will provide this information within 15 business days of receipt of this request, and you charge a fee for preparing and furnishing this information.
This authorization will expire one year from the date it was signed.

In accordance with Texas Law, the fee for preparing and furnishing medical records is $25 for the first 20 pages and 0.50 per page for each page thereafter plus the cost of postage.

Signed: _____ Date: _____