FORT BEND
fbgastroenterology
Stanley H. Stein, M.D., P.A.

Release Of Medical Records

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.

Patient's Name:________________________________**Date of Birth:**______________
SSN:____________________________**Previous Name:**__________________________
I request and authorize____
Name of Clinic/Practice

to release the medical records of the patient named above to:
Name:____
Address:____
City, State:____

This request and authorization applies to:
__________Health care information relating to the following treatments, conditions or dates of treatment:____
__________All Health care information.
__________Other:____

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

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

HIV / AIDS: I consent to the release of any positive or negative test results 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:_______

____
Signature of Patient or Patient's Authorized Representative Date Signed

____
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED UNLESS STIPULATED OTHERWISE 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. Initial:_____Date:________

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