Pleasant Ridge Internal Medicine
817-635-6363 office
817-635-6362 fax

1806 Pleasant Ridge Rd
Arlington, TX 76015

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Name of Patient_____ Date(s) of Service_____

Date of Birth_____ Social Security Number_____

I, the undersigned, authorize the release of or request access to the information specified below from

_____

of the above-named patient's medical record(s).

PATIENT INFORMATION IS NEEDED FOR:

__ Continuing Medical Care
__ Insurance
__ Legal Purposes
__ Military
__ Personal Use
__ School
__ Social Security/Disability
__ Other:_____
_____

INFORMATION TO BE RELEASES OR ACCESSED:

__History & Physical
__ Progress Notes
__ Care Plan
__ EKG Reports
__ Operative Reports
__ Lab/Pathology Reports
__ Consultation Report
__ Discharge Summary
__ X-ray Reports/Images
__ Emergency Room Record
__ Face Sheet
__ Other _____

The above information may be release to (specify name or title of individual or the name of the organization to which records are to be released and the appropriate address):

THERESA D STRETCH, MD 817-635-6363

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

1806 W PLEASANT RIDGE RD, ARLINGTON, TX 76015

Address (Street, City, State, Zip Code)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnosis, and /or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in release programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records according to Texas Hospital Licensing law.

This authorization will expire **ONE YEAR** from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows:

Date_____ Signature_____

Patient or Legally Authorized Representative

_____

Printed Name of Patient or Legally Authorized Representative

_____ _____

For department use: MRN/Acct# Relationship to patient

REV 6/16