OAKWOOD
FAMILY MEDICINE

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Release of Medical Records

Name of Patient: _____

DOB: _____ Social Security Number: _____

I authorize the release of my protected medical records as requested below:

TO Oakwood Family Medicine
511 Oakwood Blvd., Ste. 202
Round Rock, TX 78681
P: (512)388-0511 F: (512)388-0510

FROM _____
_____
_____
_____
P: _____ F: _____

Dates Requested: *Last 2 Years only* unless otherwise specified below:

From: _____ **To:** _____

Information to be released: (Reports may include information on drug / alcohol / psychological / HIV or communicable disease treatment.)

Records requested:

☐ History & Physical ☐ Consultations ☐ EKG ☐ HIV/AIDS ☐ Progress Notes
☐ Laboratory ☐ Radiology/MRI/CT ☐ Other ☐ All Medical Records

Purpose for release of information:

☐ Personal Use ☐ Legal Purposes ☐ Insurance ☐ Continuing Medical Care
☐ Social Security/ Disability ☐ Other

I understand that I may revoke this consent anytime except to the extent that action has already been made before receipt of revocation. This authorization expires automatically one hundred eighty (180) days from the date of signature or as otherwise specified. I understand that I may be charged for copies of my medical records. I understand that these records are protected under federal/ state law and cannot be disclosed without my consent otherwise provided by law. Releasing office will not be responsible for dissemination or disclosure of your confidential medical information once we provide such information, at your request, to your health insurer, employer, attorney or other designee.

Date_____ **Signature** (patient/guardian)_____