MERCY WELLNESS CLINIC
FAMILY PRACTICE

REQUEST FOR MEDICAL RECORDS

PATIENT NAME:__________________________ **PATIENT DOB**:___________________

To ***(Physician/Office we are requesting from)***: ______________________________________

THEIR PHONE:____________________________ **FAX**:_____________________________

REQUESTING PHYSICIAN/ OFFICE: Mercy Wellness Clinic

MEDICAL RECORDS REQUESTED:

- ☐ History & Physical (within the last year)
- ☐ Lab Results (all)
- ☐ Radiology Report (all)
- ☐ Other:____

PATIENT/GUARDIAN SIGNATURE: ____

Confidentiality Notice: The information contained in this facsimile may be confidential and legally privileged. It is intended **only** for use by the individual named. If you are not the intended recipient, you are hereby notified that the disclosure, copying, distribution, or taking of any action in regard to the contents of this fax – except its direct delivery to the intended recipient – is strictly prohibited. If you have received this fax in error, please notify the sender immediately and destroy this cover sheet along with its contents, and delete it from your system, if applicable.

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MEDICAL RECORDS RELEASE FORM

PATIENT NAME:__________________________ **PATIENT DOB**:___________________

To ***(Physician/Office we are sending records to)***:______________________________________

THEIR PHONE:____________________________ **FAX**:_____________________________

MEDICAL RECORDS TO BE DISCLOSED:

- ☐ History & Physical (within the last year)
- ☐ Lab Results (all)
- ☐ Radiology Report (all)
- ☐ Other:____

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _________ Day __________ Year _________

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws

PATIENT/GUARDIAN SIGNATURE:____

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