MEDICAL RECORDS REQUEST

Patient Name: ______________________ **Date Of Birth:** ______________

Name of Person Making Request: ______________________

Relationship to Patient:

- ❑ Self
- ❑ Parent or Guardian
- ❑ Referral Physician
- ❑ Attorney
- ❑ Insurance Carrier Representative
- ❑ Other: ______________

Person/Entity Records Are Released To:

Name: ______________________

Company Name: ______________________

Address: ______________________

____

Phone Number: ____________ Fax Number: ____________

Email address: ______________________

Reason for Request:

- ❑ Patient Care
- ❑ Insurance Payment
- ❑ Personal Injury Claim
- ❑ Health Care Liability Claim
- ❑ Worker's Compensation Claim
- ❑ Other: ______________

I authorize Texas MedClinic to use or disclose ***all*** information in the medical record, including HIV/AIDS test results and drug/alcohol test results ,unless restricted by date range or limitations as listed below.

Please specifically include:

- ❑ X-rays
- ❑ Other: ______________

Date Range: ______________________

Limitations: ______________________

I agree to hold Texas MedClinic, their physicians and/or representative(s) harmless for any and all action or adverse consequences that may be taken or result from the release of this information.

This authorization will expire 30 days from the date signed, and may be revoked in writing according to our Notice of Privacy Practices.

Signature of Patient or Authorized Personal Representative **Date**

For Texas MedClinic Use Only:

Signature for release matches medical record authorization? Yes No* Nothing to Compare*

***Send request to Medical Records Technician**

Verifying Person's Name: ______________________

Method of Release:

Mailed Hand Delivered Faxed Emailed Picked Up Date: ____________

If not released, why?

Frequently Asked Questions About Medical Records Request Form

When is this form to be completed?
Each time medical records are requested, Texas MedClinic (TMC) requires documentation of the request to meet the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

What is the purpose of this form?
To authorize TMC, their physicians and/or representative(s) to release your protected health information (PHI). Your signature means that you agree to hold TMC, their physicians and/or representatives harmless for any and all action or adverse consequences that may be taken or result from the release of this information.

How long does this release stay in effect?
For 30 days from the time you sign and date it, unless you specify differently in the limitations section of the form.

How can this release be revoked earlier than its expiration date?
The authorization may be revoked at any time, provided the request is in writing and addressed to TMC's Privacy Officer. Any disclosures TMC made while the authorization was in place are valid and are not affected by the revocation. TMC is not responsible for any usage of disclosure of your PHI by the recipient.

What information is required on this form?
The required information is highlighted on the form and includes the patient's name, date of birth; the name of the person requesting the information, their contact number; the reason for the request; and the patient's/guardian's signature and date.

What is purpose of the Limitations line?
This is the place to identify any records that should not be included in the release (e.g., Drug or Alcohol test results, HIV/AIDS test results, etc.)

What is TMC's contact information in case I need to call or mail a request?
Texas MedClinic
Attn: Medical Records
13722 Embassy Row
San Antonio, Tx 78216
Phone: (210) 349-5577 ext. 8830
Fax: (210) 491-2862
Email: MedRec@texasmedclinic.com