

Family Health Clinic of Texoma
3500 Old Iowa Park Rd.
Wichita Falls, TX 76301-0546
Phone: 940-851-9900
Fax: 940-851-8089

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the following protected health information to be released from the medical record of :

Last Name: _____ First Name: _____

Date of Birth: _____ Phone#: _____

RELEASE RECORDS FROM: _____

RELEASE RECORDS TO: Family Health Clinic of Texoma
PO Box 3546
Wichita Falls, TX 76301-0546
Phone: 940-851-9900
Fax: 940-851-8089

- Please mail my records
- Please call when my records are ready for pick-up
- Please fax my records

To be released: My complete record Other _____

I understand that this authorization is valid for 90 days unless I notify Family Health Clinic of Texoma otherwise. I may revoke this authorization in writing at any time except to the extent that FHCT has already relied on this authorization. I understand that the records released may include information relating to Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse; or mental or behavioral health; or psychiatric care. I understand my treatment will not be conditioned by my completion of this form.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE/GUARDIAN:
