
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PLEASE PRINT

Patient Name _____

Patient's DOB _____ Last 4 of patient's social _____

Phone Number: _____

Would you like us to call you when your records are ready? **Y / N**

I authorize **Minor Emergency of Denton** to release the necessary information from my medical records to the following persons I have listed below (please include all information: phone and fax numbers and address):

I authorize the listed person(s) below to release my medical information TO **Minor Emergency of Denton** (please include all information: phone and fax numbers and address):

I am requesting the following information (please initial by the appropriate line):

Office notes: _____

Lab results: _____

X-Rays: _____ (please note if x-rays are taken out of the clinic they need to be returned in a timely manner)

Other: _____

Minor Emergency of Denton may disclose all or part of this patient's records to any insurance company, association or Federal/State Government as may be necessary for the completion of all claims. A copy shall be as valid as the original. Please allow 7-14 business days for copying of this patient's records. There is \$25.00 fee for the first 15 pages and 50 cents for each additional page. Please make checks payable to M.E.D. There is no charge for doctor to doctor requests. **M.E.D. WILL NOT** release records until this form is completely filled out.

Patient / Guardian Signature: _____ Date: _____

Witness / Office Staff Signature: _____ Date: _____