PRIMECARE MEDICAL GROUP

Medical Records Release Consent

I, _____, hereby request and authorize my medical records be released to:

PrimeCare Medical Group
929 Gessner, Suite 2450
Houston, TX 77024

From:_____
_____
_____

Phone:_____ Fax:_____

To release the complete medical records in your possession concerning my illness and/or treatment from_____ to _____.

This authorization applies to all of the reports checked:
____My complete health record (with the exception of the following information):
____Mental Health Records
____Communicable diseases (including HIV and AIDS)
____Alcohol/drug abuse treatment
____Other (please specify)

PURPOSE OF DISCLOSURE

☐Attorney/Legal
☐Insurance Claim Processing
☐Personal Use
☐Insurance Policy Approval
☐Continued Patient Care
☐Moving
☐Workers' Compensation
☐Referral
☐Physician No Longer Accepts My Insurance

☐Other_____

PLEASE FAX RECORDS TO OUR SECURE HIPAA FAX: 713-464-9942. IF MORE THAN 15 PAGES PLEASE MAIL TO ABOVE ADDRESS.

I understand this consent can be REVOKED at any time except to the extent that disclosure made in good faith has already occurred in reliance on this account.

Signed_____ _____
Patient or Representative Date of Birth

_____ _____
Witness Date Signed

Revised 03/18/2015