CLEAR LAKE
FAMILY PHYSICIANS

JOE E. POUZAR, MD LINDA C. POUZAR, MD THRIVENI VELLORE, MD SHALLA PROCTOR, PA HANNAH WAGGETTE, PA-C TERRIE WILLIAMS, PA-C

Authorization for Release of Medical Records

Patient Name:____
Last First Middle

Street Address:____

City____ State__________ Zip____________________

Phone________________________________Email____

DOB______________________________

I hereby request that following specified medical records and reports concerning the above named patient:

[ ] Be released from the below specified clinic/doctor and sent to Clear Lake Family Physicians

or;

[ ] Be sent to the facility or doctor as specified below from Clear Lake Family Physicians

Check all that apply:

[ ] Physician's progress notes (last 3 visits free of charge, otherwise a charge may be imposed)
[ ] Laboratory reports – specify dates of service ____
[ ] Radiology reports – specify dates of service____
[ ] Medication/Prescription list
[ ] Radiology films
[ ] Complete copy of medical records (fees, if any, will be addressed at the time of your request and must be paid in advance)
[ ] Purpose of request to release patient information for Continuity of Care

If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are hereby specifically authorized to release all information relating to such records:

I **[ ]** give authorization, or **[ ]** do not give authorization to release of such records**.**

This request must be signed and dated, and may be revoked at any time except to the extent that such action has already been taken prior to the revocation. By your signature, you acknowledge your awareness that information used or disclosed to any entity other than a health plan or health provider may no longer be protected by federal privacy laws. If you are an emancipated minor, you must also sign this authorization.

This authorization does not expire and will remain in effect unless revoked by patient/caregiver.

____ _________________________
Signature of Patient, Legal guardian, or Emancipated minor Date

Records to be **[ ]** sent to or **[ ]** requested from:

Name of Doctor____

Name of Clinic____

Address____

Phone____________________________________ _______Fax____

1045 GEMINI ST STE 200-B HOUSTON, TEXAS 77058
PHONE (281) 486-7900 FAX (281) 286-8110