**Please list any physicians that you would like us to release your records to. We will not send unless requested.**

# Medical Release of Information Form

Patient Name: _____ Date of Birth: _____

Social Security #:_____Previous Name: _____

Home Phone: _____ Other Phone: _____

**To release the medical record of the above named patient to: (***be sure to list ALL necessary physicians***)**

_____

_____

**Phone: _____ Fax: _____**

**I request and authorize_____F. Jon Senkowsky M.D. - AVS_____**
**(**Name of Physician and Clinic/Practice you want to release your records)

**Address, City, State, Zip_____Arlington,TX 76012_____ Phone_____817-861-3000__ Fax_817-861-3003_**

**Reason for release (required field**):**_____Continuation of care_____**

**Health Care information relating to the following treatment condition or dates of treatment:**
**_____ALL_____**
***This information may contain x-ray reports, laboratory reports, EKG reports, other diagnostic reports, consults, etc.***

This request and authorization applies to: (initial appropriate line)

____All Health Care information **including** information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use. (Please circle all that apply)

____All Health Care Information **excluding** information relating to HIV/Aids testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use. (Please circle all that apply)

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.

Treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes.

I understand I have the right to revoke this authorization by providing a written request to do so to the above name physician or organization. I understand that the revocation will not apply to information that has already been released in good faith. I understand that the condition for release is not based on payment for treatment and care, enrollment or eligibility on whether I sign the authorization.

_____ _____
**Signature of patient or authorized representative** **Date**

_____
Relationship or status if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

**Unless otherwise revoked this Authorization will expire six months from the date signed or the following designated event:**_____
I understand that authorizing the disclosure of this health information is voluntary.