AUTHORIZATION TO RELEASE MEDICAL RECORDS

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

LAST NAME (PLEASE PRINT)	FIRST NAME	DATE OF BIRTH
ADDRESS	CITY/STATE	ZIP
PHONE NUMBER		LAST 4 SSN

Release Records TO:
IKP Family Medicine
21309 Foster Rd
Suite 100
Spring, TX 77388
Fax 281.907.6003
Phone 281.587.1700

Dr/NP: _____

Release Records FROM:
NAME/ORGANIZATION
ADDRESS
CITY/STATE & ZIP
PHONE
FAX

RECORDS TO BE RELEASED: **DATE(S) OF SERVICE:**

- ☐ ENTIRE RECORD
- ☐ OFFICE VISIT NOTES
- ☐ LAB WORK
- ☐ RADIOLOGY
- ☐ IMMUNIZATIONS
- ☐ OTHER (SPECIFY)

REASON FOR RELEASE OF INFORMATION

☐ Medical Care ☐ Legal ☐ Insurance ☐ Other: _____

NOTE: If mailing or faxing this form, please include a copy of your photo ID

Patient/Guardian Signature	Date
IKP Staff Signature	Date

This form must be signed by the patient. If the patient is a minor, it must be signed by the parent or legal guardian. If the patient is adjudicated to be incompetent, it must be signed by the legal guardian. If patient is deceased it must be signed by estate executor. To the party receiving this form: this information has been disclosed to you for records whose confidentiality may be protected by law. If so, federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or information is not sufficient for this purpose. FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2