Complex Care Medical Services

REQUEST FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patients Name:_____ Date of Birth: _____ SS#: _____

I, as the patient or legal representative of the patient, request that the following protected health information (medical records), be released for treatment purposes:

☐ All medical records of the patient indicated above

☐ Other: _____

I understand that the records released may include information relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS) and/or treatment for, or history of drug or alcohol abuse, mental, behavioral or psychiatric care. I understand that this authorization is voluntary and I may refuse to sign this authorization.

Release Records From:

Name:	**Name:**
Address:	**Address:**
City/State/Zip:	**City/State/Zip:**
Phone Number:	**Phone Number:**
Fax Number:	**Fax Number:**

Name:	**Name:**
Address:	**Address:**
City/State/Zip:	**City/State/Zip:**
Phone Number:	**Phone Number:**
Fax Number:	**Fax Number:**

Please send records to:

Complex Care Medical Services

PO BOX 561592
Dallas, Texas 75356
Phone: 469-488-7200
Fax: 469-488-7201

I understand that federal laws and regulations do not require an authorization for release of protected health information for treatment purposes. This form is to provide a formalized written manner of communication for requesting protected health information from one health care provider to another. This request will expire in 1 year unless otherwise revoked.

_____ _____
Signature of Parent or Legal Guardian Printed Name of Parent or Legal Guardian

_____ _____
Relationship to Patient Date