# MEDICAL RECORDS RELEASE FORM

Goldstein & Orr

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**NAME:** ______________________________________________ **DOB:** Month _____Day _____ Year______

**By signing this form, I authorize the release of confidential protected health information about me to the person(s) or entity listed below. I hereby authorize Cynthia Orr, Attorney to:**

**SELECT THE FOLLOWING:** ☐ Obtain health information from ☐ Send health information to

Name: ____________________________________________________________________
Address: ___________________________________________________________________
Phone#:_______________________ Fax#: ________________________

**WHAT INFORMATION CAN BE DISCLOSED?**

☐ Complete Record ☐ Neuropsychology report and scores
☐ Records of care from the following dates: ______________________________
☐ Confer with the person listed above orally regarding my medical information
☐ Other: ___________________________________________________________________

**Your initials are required to release the following information:**

______Mental Health Records (excluding psychotherapy notes) ______ HIV/AIDS Test Results/Treatment
______Drug, Alcohol, or Substance Abuse Records ______Genetic Information (including Genetic Test Results)

**REASON FOR DISCLOSURE** (Choose only one option below)

☐ Treatment/Continuing Medical Care ☐ Legal Purposes ☐ Employment
☐ Other: ___________________________________________________________________

**EFFECTIVE TIME PERIOD.** This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _________ Day __________ Year _________

**RIGHT TO REVOKE:** I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to Cynthia Orr, Attorney at Law. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

**SIGNATURE AUTHORIZATION:** I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

**SIGNATURE X** ____________________________________ ______________________________
Signature of Individual or Individual's Legally Authorized Representative Date

Printed Name of Legally Authorized Representative (if applicable):______________________________________________
Relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other ___________________________

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam.Code § 32.003).

**SIGNATURE X**____________________________________ ______________________________
Signature of Minor Date

**PLEASE PROVIDE RECORDS VIA FAX 210.226.8367 or EMAIL whitecollarlaw@gmail.com**