MEDICAL RECORD RELEASE FORM

FamilyMedix

9701 Richmond Ave, Suite 220, Houston TX 77042

Phone: 713-715-1234 Fax: **833-305-2389**

- **Patient Name:**
- **Date of Birth:**

I hereby authorize the below listed entity to release medical information to Dr. Parinaz Neshati, MD, with FamilyMedix.

- **Your Previous Doctor or medical facility Name:** ______________________________
- **Address:** ______________________________
- **Phone#**: ______________________________
- **Fax#** ______________________________

Medical Information Requested:

☐ All Records

☐ Specific Records from ______________ to _______________

☐ Immunizations & Physical Examinations

☐ Radiology Films {X-Ray, Mammography, Ultrasound, CT, MRI, etc.}

Signature of Patient or Legal Guardian: _________________ ***Date:*** __________

This release authorizes the disclosure of records for one year from the date signed above. I understand that these records are protected under Federal and/or State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.