TEXAS GULF COAST
medical systems

PHONE: (281) 604-1300 FAX: (281) 724-0355

Print Form

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO TGCMG

Fillable Form

NOTE: This form can be filled out from your screen. Just click in the open space beside each query and type in the requested info.

You can click "Highlight Fields" in the top right corner of your PDF Reader to view all the fillable areas. Click the 'email' and/or 'print' button(s) above when finished.

***Any required signatures must be signed in ink on a printed copy of this form prior to validation.**

PATIENT INFORMATION	Date: Day Month Year

Patient Name: Last First Middle Maiden Name

Date of Birth:	Social Security Number:

Address:	City:	State:	Zip:

Home Phone:	Other Phone:

From Whom

I hereby authorize (Name of Doctor, Hospital or other Medical Provider):

Address:	Phone:	Fax:

...to release my medical records as identified below to TEXAS GULF COAST MEDICAL GROUP, PLLC at the address and/or FAX number listed above.

This release is to be: ☐ Mailed ☐ Faxed ☐ Picked up in peron by patient

FOR THE PURPOSE OF MEDICAL CARE

What to Disclose My authorization extends only to those data elements/documents checked below:

- ☐ Statements of charges/payments
- ☐ Historical & physical examinations
- ☐ Consultation reports
- ☐ Hepatitis information
- ☐ Laboratory reports
- ☐ Medication Lists/Prescription Lists
- ☐ Discharge Summary
- ☐ Last 3 visits only (No charge)
- ☐ Record of visits (all visits)
- ☐ Copies of reports/reports (i.e. hospital, other physicians)
- ☐ AIDS (Acquired immunodeficiency) or HIV (Human Immunodeficiency Virus)
- ☐ Mental health and/or Alcohol and Drug Abuse treatment
- ☐ Radiology reports (Films are release/copied by Radiology Dept.)
- ☐ Photographs
- ☐ All of the above, except

This authorization is given freely with the understanding that the information will be used per my direction and in accordance with the terms on the second page (reverse side) of this form.

Signature (second page/reverse side must be signed also)	Printed Name

Continued on the next page .../

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Texas GULF COAST MEDICAL GROUP

THIS AUTHORIZATION IS GIVEN FREELY WITH THE UNDERSTANDING THAT:

1. Any and all records whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is valid as the original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one (1) year period from the date it is signed, or sooner if noted below. THE REVOCATION MUST BE IN WRITING. You may request revocation notice by requesting one in person, sending written request for the form or by calling TGCMG at (281) 604-1300.
4. Texas Gulf Coast Medical Group, PLLC, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
5. Treatment, payment, enrollment or eligibility for benefits are not conditioned upon obtaining this Authorization
6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

Printed Name of Patient:	Date:
Patient's Signature or Guardian of Minor:	
Expiry Date (if other than one (1) year:	Social Security Number (for ID purposes):
Patient's Personal Representative:	
Patient's Personal Representative Authority to Act:	
Witness:	
Identitification Verification: ☐ Driver's License ☐ Green Card ☐ Other, specify	
Name / Initials of person making verification	

250 Blossom, Suite 300 Webster, TX. 77598