

**TEXAS GULF COAST***medical systems***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		Day	Month	Year
Date:				
Patient Name:	Last	First	Middle	Maiden Name
Date of Birth:	Social Security Number:			
Address:	City:	State:	Zip:	
Home Phone:	Other Phone:			
<b>From Whom</b>				
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				
<b>What to Disclose</b> My authorization extends only to those data elements/documents checked below:				
Statements of charges/payments	Record of visits (all visits)			
Historical & physical examinations	Copies of reports/reports (i.e. hospital, other physicians)			
Consultation reports	AIDS (Acquired immunodeficiency) or HIV (Human Immunodeficiency Virus)			
Hepatitis information	Mental health and/or Alcohol and Drug Abuse treatment			
Laboratory reports	Radiology reports (Films are release/copied by Radiology Dept.)			
Medication Lists/Prescription Lists	Photographs			
Discharge Summary	All of the above, except			
Last 3 visits only (No charge)				
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		



**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: <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 15px; height: 15px;"> </td> <td style="width: 15px; height: 15px;"> </td> <td style="width: 15px; height: 15px;"> </td> <td style="width: 15px; height: 15px;"> </td> <td style="width: 15px; height: 15px;"> </td> <td style="width: 15px; height: 15px;"> </td> <td style="width: 15px; height: 15px;"> </td> <td style="width: 15px; height: 15px;"> </td> </tr> </table>								

Patient's Signature or Guardian of Minor:

Expiry Date (if other than one (1) year): <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 15px; height: 15px;"> </td> <td style="width: 15px; height: 15px;"> </td> <td style="width: 15px; height: 15px;"> </td> <td style="width: 15px; height: 15px;"> </td> <td style="width: 15px; height: 15px;"> </td> <td style="width: 15px; height: 15px;"> </td> <td style="width: 15px; height: 15px;"> </td> <td style="width: 15px; height: 15px;"> </td> </tr> </table>									Social Security Number (for ID purposes):

Patient's Personal Representative:

Patient's Personal Representative Authority to Act:

Witness:

Identification Verification:	Driver's License	Green Card	Other, specify
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Name / Initials of person making verification