PHONE: (281) 604-1300

TEXAS GULF COAST
medical systems

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS FROM TGCMS

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:	Email Address:

Address:	City:	State:	Zip:

Home Phone:	Other Phone:

How to Disclose

I hereby authorize Texas Gulf Coast Medical System to disclose requested information in my medical record by

Mail Fax Email Personal pick up *if other than parent or guardian, specify name

Disclose to (complete name and title of person whom to disclosure is to be made - input below)

Phone # Fax #

Address:	City:	State:	Zip:

For the purpose of:

☐ Medical Care ☐ Attorney/Legal ☐ Insurance ☐ Personal
☐ Disability ☐ Review Only ☐ Other

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

- ☐ Statements of charges/payments
- ☐ Historical & physical examinations
- ☐ Consultation
- ☐ Hepatitis information
- ☐ Laboratory reports
- ☐ Medication Lists/Prescription Lists
- ☐ Discharge Summary
- ☐ 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 / Photographs
- ☐ Immunizations
- ☐ 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

250 Blossom, Suite 300 Webster, TX. 77598

Continued on the next page .../

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 TGCMS at (281) 604-1300.
4. Texas Gulf Coast Medical System, 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:

Expiration Date (if other than one (1) year:

Patient's Personal Representative:

Patient's Personal Representative Authority to Act:

Witness:

Identification Verification: Driver's License Green Card Other, specify

Name / Initials of person making verification

Note:

If release is more than one party, separate forms must be completed and signed.
Texas Gulf Coast Medical System reserves the right to require appropriate identification for each medical record release and To verify FAX requests.

Internal use only) FAX release form was verified by _____(Method)_____(Name)