Grace Health & Wellness Clinic
1601 Main Street
STE 404
Richmond, TX 77469
Phone: (346) 444-3653 / Fax: (855) 576-4465

Medical Records Release

Patient Information			
Name (First, Middle, Last):			DOB:
Address:	City:	State:	Zip:
Phone #:	Email:	Medical Record #:	

Records Request Details

Entity Releasing Records			
Entity Name:		Contact Name:	
Address:	City:	State:	Zip:
Phone #:	Fax #:	Email:	
Entity Receiving Records			
Entity Name:		Contact Name:	
Address:	City:	State:	Zip:
Phone #:	Fax #:	Email:	
Information Release Details			
Effective Time Period:			
Purpose of Release:			

Type of Records Being Released (check all that apply):

- ☐ All Medical Records
- ☐ Urgent Care Notes
- ☐ Operative Notes
- ☐ Discharge Summaries
- ☐ Laboratory Reports
- ☐ Patient Billing Records
- ☐ Emergency Room Notes
- ☐ Progress Notes
- ☐ Radiology Reports
- ☐ Film/CD Imaging
- ☐ Clinical Notes
- ☐ Nursing Notes
- ☐ History & Physical
- ☐ Providers Orders
- ☐ Consultations
- ☐ Other:

Release of Sensitive Medical Info (check all that apply):

- ☐ Mental Health/Psychiatric Treatment
- ☐ Genetic Testing Information
- ☐ Alcohol or Substance Abuse Treatment
- ☐ STD/HIV/AIDS Treatment(s) or test(s)
- ☐ Additional Info:

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Formate:	Delivery Method:	
☐ Email Address noted above, where permitted	☐ US Mail	☐ Overnight/Express
☐ CD	☐ Pick-up	☐ Certified
☐ Paper copy	☐ Fax	☐ Other:
☐ Other:	☐ Email	

Patient's Rights

Patient Rights
I understand that: ● I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to the releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice. ● Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in a health plan, or eligibility for benefits. ● I have a right to a copy of this Authorization.

Authorization

Signature of Patient or Patient's Representative _____ Date _____

Printed Name _____ Representative's Relationship to Patient _____

Witness (optional) _____ Date _____