Medical Records Department **1237 Campbell Road, Houston TX 77055**
Ph. 713-365-9099 Fax 713-365-9356

Authorization to Use and Disclose Health Information

Patient Name:	Date of Birth:
Other Names Used:	

I, the undersigned, authorize the release of or request access to the information specified below from the medical record(s) of the above named patient.

☐ Specific Date(s) of treatment:_____ ☐ All

Records will be used for:
☐ Continuing Medical Care ☐ Personal Use ☐ Legal Purposes ☐ Social Security/Disability

Requesting Records **From**: _____
(Doctor's Full Name)

To: _____
(Doctor's Full Name)

_____
(Address)

_____ _____
(Phone Number) (Fax Number)

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I would like this authorization to be in effect until: _____
I understand the information in my health records may include information relating to sexually transmitted disease, AIDS or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
__*Yes*, I consent to the release of the above information. __ *No*, I do not consent to the release of the above information.

I understand that my medical records may contain reports, test results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding entries made in my medical record to prevent misunderstanding of the information contained in these entries. I will not hold WVG liable for any misinterpretation of the information in my medical records as a result for not consulting my physician for the correct interpretation.

_____ _____
Patient/Guardian Signature **Date**

_____ _____
Relationship to Patient **Witness**