Authorization to Release or Obtain Medical Record

I,______________________________(Patient or Legal Representative) DOB:______________________

Authorize:

☐ Orthopedic Clinic of Galveston County
6501 Memorial Dr.
Texas City, TX 77591
(phone) 409-938-8161 (fax) 409-938-0837

Or Other (specify below)

☐ Name of Person or Facility______________________________________
Address:____
City:______________________________ State:_______ Zip:___________
Phone:____________________________ Fax:_______________________

☐To release information to:
☐To obtain information from:

Name of Person or Facility:____
Adress:____
City:____State:_________Zip___________

Purpose of this Authorization:____

I authorize the release of the following protected health Information. (Check all the boxes that you want to release or want to obtain):

☐Entire record from ____________(date) to ______________ (date)
☐Consultation notes/report
☐Lab reports
☐Diagnostic images and imagining reports
☐Surgical reports
☐Medical history
☐Examination reports
☐Treatment or Test
☐All hospital records (including reports, nursing records, progress notes)
☐Other____

For personal copies of your medical records, the cost will be $25.00 for the first 25 pages and .25 cents for each page thereafter. Please allow 10 days from the day of request to process your request for medical records.

____ _________________________
Signature of Patient or Patient's Legal Representative Date

____ _________________________
Printed Name of Patient or Legal Representative Relationship to Patient

Office Use:
Received by:____ Date:____________________