The Oaks Healthcare Center
20121 W. Lake Houston Pkwy. #1600
Humble, TX 77346

Phone: 281-852-8724
Fax: 281-929-0390
www.drbush.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize release of my healthcare records as stated herein. I understand that I have a right to inspect and receive a copy of the disclosed material. This authorization will remain in effect until the expiration date or this request is revoked through written notice submitted to the entity releasing the records.

Any revocation is not effective to the extent that the office/clinic has already released records in reliance on this form.

If this form is signed by a person other than the patient, their relationship to the patient and their authority to sign this authorization much be indicated below.

NOTICE TO PATIENT

Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether the patient signs this form, unless permitted by law.

Patient Name: _____ DOB: _____ Date: _____

Signature: _____ Relationship: _____

RECORDS TO BE RELEASED TO

Name/Office: _____ Phone: _____

Address: _____ Fax: _____

RECORDS TO BE RELEASED FROM

Name/Office: _____ Phone: _____

Address: _____ Fax: _____

DATES OF SERVICE REQUESTED

_____

INFORMATION TO BE RELEASED

o Exam Reports o X-Ray Reports o Daily Notes o Lab Reports o Billing o Other _____