MEDICAL RECORDS/INFORMATION RELEASE FORM

TO: GREATER HOUSTON FAMILY MEDICINE

I hereby request and authorize GREATER HOUSTON FAMILY MEDICINE, and/or his employees to release copies of my medical records and/or discuss confidential medical information regarding my medical history, condition, treatment, test results, etc. with the following person(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Such release may include information which may be considered a communicable or venereal disease which may include, but is not limited to diseases such as Hepatitis, Syphilis, Gonorrhea, and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS)

Name: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip: _____

Patient's Signature: _____

Social Security #: _____ Date: _____

Witness: _____ Date: _____