RELEASE OF MEDICAL RECORDS

Capstone Family Practice, PA
6401 Cypresswood Drive, Suite 180, Spring, TX 77379
281-866-7080 (tel) 281-866-7151 (fax)

Name: _____ Date of Birth: _____ /_____ /_____

Address: _____ SSN: _____-_____-_____

☐ **I hereby authorize Andy Spafford, MD; Tina Corkran, MD; and Grace Lee, D.O. to obtain confidential information from:**

Name: _____Telephone: _____

Address: _____Fax: _____

City: _____ State: _____ Zip: _____

Purpose:

- ☐ SSI/Disability
- ☐ Nursing Home Placement
- ☐ Legal/Attorney
- ☐ Continuation of Care
- ☐ Other (please specify):_____

The following will be obtained:

- ☐ Entire Record
- ☐ Diagnostic Test Results
- ☐ Discharge Summary
- ☐ History and physical exam
- ☐ Consultation Report
- ☐ ER Records
- ☐ OP Records
- ☐ Pathology Records
- ☐ Other (please specify): _____

I understand that I may revoke this authorization in writing at any time prior to the release of information specified above. I hold harmless Andy Spafford, MD; Tina Corkran, MD; Grace Lee, D.O. and/or his/her representatives from liability resulting from the release/obtaining of the above information. This authorization expires 90 days from the date signed. Pursuant to state and federal law, you are hereby advised that the information that you authorized for release may include any/all results, diagnosis, and/or treatment for HIV, STD's, psychiatric disorders, or drug and alcohol abuse.

_____ or _____ _____
Signature of Patient Signature of Guardian Date

Notice to recipients of information: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42, CFR Part 2) prohibit you from making any further disclosures without written consent.