Texas Rheumatology

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AUTHORIZATION TO RELEASE/OBTAIN MEDICAL INFORMATION

Patient Name: ____

Print patient name

Previous Name: ____

Social Security Number: _____/_____/______ Date of Birth: _____/_____/______

I hereby, authorize ______________________________ to release healthcare information of the patient's name above to **Texas Rheumatology.**

This request and authorization apply to:

- All healthcare information, including HIV/AIDS and mental health information.
- Health information related to the treatment, condition, or dates

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- Other Labs & X-rays only, radiology

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ALL HEALTH INFORMATION REQUESTED IS FOR CONTINUITY OF CARE.

I understand that, except for actions already taken, this authorization may be voided by me at any time. This authorization may be revoked by written communication to the Medical Records Department.

THIS AUTHORIZATION IS VALID FOR 12 MONTHS AFTER THE DATE SIGNED BY THE PATIENT OR LEGAL REPRESENTATIVE.

____ Date: ________________________

Patient Signature [or parent, guardian, or legal representative]

____ Date: ________________________

TR Employee Signature