

Urology Tyler, PA  
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Tyler, Texas 75702  
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## MEDICAL RECORDS RELEASE FORM

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

This authorizes \_\_\_\_\_ to provide a copy, summary, or narrative of my medical records (as indicated by the checkmark(s) below) or otherwise release confidential information.

- Complete Record.
- Records of care from the following dates: \_\_\_\_\_ to \_\_\_\_\_.
- Records concerning the following conditions: \_\_\_\_\_
- Other, (specify): \_\_\_\_\_
- Confer with person(s) listed below orally about my medical information.

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**HIV/AIDS:** I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **Initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
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Release to the following person(s):

Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

The reasons or purposes for this release of information are as follows:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

By signing this form, I understand and agree that you will provide this information within 30 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

Revised 12/00