Liver Associates of Texas, P.A.
6410 Fannin Street Suite 225, Houston, TX 77030
Tel (713)799-8300 Fax (713)799-8305

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name _____

Date of Birth _____ Gender _____ Social Security # _____

Address _____

Telephone _____ Alternate Telephone _____

I hereby authorize _____ _____ _____
(Name of Facility/Hospital/Doctor) (Phone) (Fax)

to release my medical records from _____ **to** _____ **to**
(date) (date)

_____ _____ _____
(Name of Facility/Hospital/Doctor) (Phone) (Fax)

☐ *H & P clinic notes* ☐ *Imaging Studies (Ultrasound, CT Scan, MRI etc)* ☐ *Colonoscopy / EGD*

☐ *Lab Results* ☐ *Hospital Discharge Summary* ☐ *Liver Biopsy* ☐ *Other* _____

Purpose for Release of Medical Records : **MEDICAL CARE**

Please fax my medical records to _____ and attention to _____

This authorization expires 365 days (1 year) from the date signed below and covers treatment(s) at Liver Associates of Texas.

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, Hepatitis, HIV testing, HIV results, and AIDS information.

I, the undersigned, have read the above and authorize the staff of Liver Associates of Texas to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. This facility is released and discharged of all legal responsibility and liability resulting from release of this information and I, the undersigned, waive on behalf of myself, my heirs, assigns and any person who may have and interest in the matter, all provisions of law relating to the disclosure of the Protected Health Information.

_____ X _____ _____
Date Signature of Patient / Parent / Guardian Authority/Relationship to Patient