LEGACY COMMUNITY HEALTH

OFFICE USE ONLY:

MRN: _____ Pmt Recvd: _____

Date Received:_____ Amount: $_____

AUTHORIZATION TO RELEASE or REQUEST MEDICAL INFORMATION

Requesting the records of:

Patient LAST Name: _____ Patient FIRST Name _____

Date of Birth: _____ Phone # _____

Person Completing Request:

PRINT First Name: _____ PRINT Last Name: _____

Relationship to Patient: _____ ID# _____ ID Type _____

I, the undersigned, hereby authorize Legacy Community Health, P.O. Box 66308, Houston, TX 77266 to:
○ Release medical information to / or ○ Request medical information from those indicated below:

_____ _____
Name of Provider/Organization/Entity/Person Phone Number

_____ _____ _____ _____ _____
Address City State Zip Code Fax Number

Dates of Service or Range of Dates: _____ to _____

INFORMATION TO BE DISCLOSED (Must be Indicated)

- ☐ **Chart Summary**
- ☐ **Primary Care Records**
- ☐ **Dental Records**
- ☐ **Vision Records**
- ☐ **Lab Reports or Diagnostic Testing**
- ☐ **Other (specify):**

_____

PURPOSE OF THIS DISCLOSURE (Must be Indicated)

- ☐ **Patient Request**
- ☐ **Continued Medical Care**
- ☐ **Social Security Disability Determination**
- ☐ **Legal or other Judicial Proceeding**
- ☐ **Verify Claims / Benefits**
- ☐ **Other (specify):**

_____

I specifically authorize disclosure of the following information: (*absent authorization this information is withheld*).

- ☐ **STD Documentation**
- ☐ **HIV/AIDS Documentation**
- ☐ **Behavioral Health Records**
- ☐ **Alcohol and/or Drug Abuse History**
- ☐ **Developmental Disabilities Documentation**

Initial:_____

RIGHTS REGARDING AUTHORIZATION: Patients, or their legally authorized representative, have a right to inspect or receive a copy of this health information to be used or disclosed. Patients, or their legally authorized representative, have a right to withdraw this authorization. Written notification is necessary to revoke this authorization. This authorization will be valid for one year unless revoked in writing by the patient, or their legally authorized representative.

Per Texas Health & Safety Code 241.151 & 241.154: For paper copies, a charge of $25 for the first 20 pages and 50 cents for each page thereafter. For electronic copies, a fee of $25 for up to 500 pages, $50 if over 500 pages (if provided on CD add $1 for cost of the CD).

_____ _____ _____
Signature of Patient or Legal Representative PRINT Name Date

_____ _____ _____
Signature of Legacy Witness PRINT Name Date

Mail to: Medical Records, Legacy Community Health, P.O. Box 66308, Houston, TX 77266

FAX to: (832)-548-5092 EMAIL To: mrecords@legacycommunityhealth.org