WILLIS
Senior Housecalls

275 Holder Trail, McKinney, TX 75071
Phone: (214) 491-4191 | Fax: (469) 519-0407
WillisSeniorHousecalls.com

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name _____ Date of Birth _____

Date(s) of Service _____ SSN _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION NEEDED FOR:

☐ Military ☐ Continuing Medical Care ☐ Social Security/Disability

☐ Insurance ☐ Personal Use ☐ Other:

☐ Legal Purposes ☐ School _____

INFORMATION TO BE RELEASED OR ACCESSED:

☐ History and Physical ☐ Consultation Report ☐ Emergency Room Record

☐ Operative Reports ☐ Discharge/Death Summary ☐ Face Sheet

☐ Lab/Path Reports ☐ X-ray Reports/Images ☐ Other: _____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO

_____
Doctor, Hospital, Attorney, Insurance Company, Self, etc.

_____
Address

_____ _____ _____
City State ZIP Code

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FROM

_____

Doctor, Hospital, Attorney, Insurance Company, Self, etc.

_____

Address

_____ _____ _____

City State ZIP Code

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire one (1) year from the date of my signature, unless I revoke the authorization prior to that time.

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____ _____

Printed Name of Patient or Legally Authorized Representative Relation