Medical Records Release Form
Sandip V. Mathur MD, P.O. Box 5496,Abilene, Texas 79608 (325)692-3777

To: _____
_____
_____

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information to the person(s) or entity listed below.

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.
Initial:_____ Date:_____

Limitations on the information you may release subject to this Release Form are as follows:

_____

Release my protected health information to the following person(s)/entity:

Name: _____

Street: _____

City: _____ State: _____ Zip: _____

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

_____

Patient signature (or parent, guardian or legal representative):

_____ D.O.B.: _____

Date: _____

I understand that you will provide this information within 15 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.

SUMMARY