MEDICAL RECORDS RELEASE FORM

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

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PHYSICIAN, HOSPITAL, OR CLINIC NAME

ADDRESS

CITY **STATE** **ZIP**

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

Springtown Family Health Center
Gene McDaniel, D.O.
Chris Opella , M.D.
P. O Box 1039 – 308 West Hwy 199
Springtown, TX 76082
(817) 523-5402
Fax(817) 523-5422

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

At the request of the individual

Medical management

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

Patient's Signature (or parent, guardian or legal representative): Date:

Patient's Name: **D.O B.**

Patient's Address: