Louetta Family Medicine
5834 Louetta Road, Suite F
Spring, TX 77379
Tel: 832-698-4291
Fax: 832-698-4297

Medical Records Release Authorization Form

Patient Name: _____ DOB:_____

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

RECORDS ON DISCS/CD's NOT ACCEPTED

From:_____ To: Louetta Family Medicine

Phone:_____ Phone: 832-698-4291

Fax:_____ Fax: 832-698-4297

The health information you may release subject to this authorization is as follows:

_____ All medical records _____ Lab _____ Radiology _____ Consult Notes

From service date: _____ to _____.

Your initials are required to release the following information:

- HIV/AIDS test results/treatment _____
- Drug, Alcohol, Substance Abuse Records _____
- Genetic information (including genetic test results) _____
- Mental Health Records (excluding counseling notes) _____

The purpose for this release of information is for patient care and treatment. This authorization shall be in force and effective for 30 DAYS from the date below. By signing this form, I authorize you to use and disclose the protected health information. I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to Louetta Family Medicine at the address above. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer by protected by Federal HIPPA privacy regulations.

_____ _____

Signature of Patient or Personal Representative Witness

_____

Date