GOLDEN TRIANGLE FAMILY CARE CENTER
AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name: _____
Last Name First MI.

Street Address: _____

City, State & Zip: _____

Social Security Number: _____ Date of Birth: _____

I hereby request: _____

_____

to furnish a copy of the medical records of the patient named above for the period of _____,

_____ to _____, _____ to:

GOLDEN TRIANGLE FAMILY CARE CENTER
Dr. Chris Penning, Dr. Servet Satir, Stephanie Hyden, FNP
615 W ROUNDBUNCH RD
BRIDGE CITY, TEXAS 77611
409-735-7305
409-735-3371 FAX

Purpose for Release: _____

_____ I authorize the release of my complete medical record.
_____ If applicable to my treatment I understand my medical record will contain information regarding the following treatment or testing, authorized by my signature(s) below.
_____ I authorize the release of my HIV/AIDS status & testing.
_____ I authorize the release of information regarding drug & alcohol abuse.
_____ I authorize the release of information regarding psychological disorders.
_____ I authorize the partial release of my medical record to include only the following:
_____

I hereby release your physician and employees from liability associated with release of this information. I understand this information has been disclosed to me from records whose confidentiality is protected by Federal Law. I understand that Federal regulations prohibit me from making any further disclosure of this information except with specific written consent of the patient. This authorization will expire 90 days from the date of my signature.

SIGNATURE: _____
(Patient, Parent or Guardian if a minor, or Legal Representative)

RELATIONSHIP TO PATIENT: _____ Date: _____

OFFICE USE ONLY

REQUEST/RECORDS SENT BY: _____ DATE: _____