HCM Medical Group
205 W. Windcrest, Ste. 130
Fredericksburg, TX 78624
hcmmedicalgroup.com

MED RECORD NO.

I hereby authorize you to release information from the medical record of**:**

PATIENT NAME	DATE OF BIRTH

The information is to be released:

Circle One **To** **From**	NAME ADDRESS / City / State / Zip PHONE: FAX:	Circle One **To** **From**	HCM Medical Group 205 W. Windcrest, Ste. 130 Fredericksburg, TX 78624 Ph: 830-990-1404 Fx: ___________________

INFORMATION TO BE RELEASED				
	Visit Notes		Lab Report	DATE OF SERVICE
	Pathology Report		Itemized Bill	
	Other, please specify:			

PURPOSE OF DISCLOSURE			
	Attorney/Legal		Continued Patient Care
	Insurance		Personal Use
	Other:		

It is understood that the information released is for the specific purpose stated above and may not be provided in whole or in part to any other agency, organization or person. I understand that records from other health care providers will not be released with this request. I hereby waive my/his/her right to the privileges of confidentiality with respect to any HIV test result or mental health information or drug and alcohol information that may be contained in the medical record. The health care provider, its employees and officers and physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. A photocopy or facsimile of this authorization shall be deemed to have the same force and effect as the original. I further understand that I may revoke this consent in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance thereon. This consent will expire 180 days after date of signature. If the PHI is re-released or if the release is to a non-covered entity it will no longer be protected.

SIGNATURE OF PATIENT	DATE
SIGNATURE OF PATIENT/GUARDIAN (if required)	DATE
SIGNATURE OF WITNESS	DATE

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