AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, ________________________________, ____________________, hereby authorize:
[PRINT PATIENT NAME] [DOB]

Helical Health, PLLC
8845 Davis Blvd, Ste 100
Keller, TX 76248

817.900.9525 Phone
817.900.9545 Fax

☐ To obtain a copy of records FROM:
☐ To release a copy of records TO:

[PRINT NAME OF OUTSIDE FACILITY/DOCTOR/MEDICAL PROVIDER]:

Name: ____

Address: ____

Phone: ______________________ Fax: ______________________

To include the following health information:

☐ All records
☐ Partial records: ______________________________________

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose of patient care.
- This authorization is in effect until revoked. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily. Treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

______________________________ ______________________________
Signature of Patient/Legal Guardian Date

______________________________ ______________________________
Print Name of Patient/Legal Guardian Relationship to Patient