

Richard L. Grandjean, M.D., P.A.

Diplomate, American Board of Family Medicine
Fellow, American Academy of Family Physicians

Office (214) 327-3333 | Fax (469) 364-6138

Forest Park Family Medicine
12222 N. Central Expy., Suite 200 (LB12)
Dallas, Texas 75243-759

Raintree Family Medicine
997 Raintree Circle, Suite 180 (LB8)
Allen, Texas 75013-4949

**MEDICAL RECORDS RELEASE
AUTHORIZATION (OUTGOING)**

Patient Name: _____
Last First MI

Date of Birth: _____ Last 4 of SSN: _____

- I hereby authorize: Raintree Family Medicine | Richard L. Grandjean, M.D., P.A.
997 Raintree Circle, Suite 180 (LB8) | Allen, Texas 75013-4949
- Forest Park Family Medicine | Richard L. Grandjean, M.D., P.A.
12222 N. Central Expy., Suite 200 (LB12) | Dallas, Texas 75243

to release the following medical records to: _____

This authorization applies to the following records:

- _____ Any and all records;
- _____ Records pertaining to illness/injury occurring between _____ and _____;
- _____ Records from _____ to _____;
- _____ Specific reports: _____
- | | | |
|----------------------------|-----------------------|----------------------|
| Hospital Discharge Summary | Operative Summary | Radiology Reports |
| Emergency Department Visit | Laboratory Reports | Progress Notes |
| Drug/Alcohol Testing* | Mental Health Notes** | Psychotherapy Notes* |
| Other _____ | | |

- | | | | |
|---------------------|---------------------------|-----------------------|--------------------------------|
| Purpose of request: | Coordination of care** | Specialist referral** | Transfer of medical records*** |
| | Insurance Underwriting*** | Legal review*** | Personal copy of records*** |

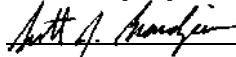
I understand the purpose of this release is to clarify and enhance my care and treatment. Further, records may contain reference to or results of HIV antibody (AIDS), drug, alcohol testing and or mental health information, with my consent.

A duplicate or photostatic copy or facsimile reproduction of this authorization may be used in lieu of the original. You are hereby released from all liability arising out of, or in any way incident to, producing records or providing information pursuant to this authorization.

Signature of patient or responsible party

Date

Relationship to patient if other than self



Signature of Witness

* Requests for release of drug/alcohol testing and mental health or psychotherapy notes require written authorization from the patient.

** A signed authorization is not required for coordination of care or specialist referral requests.

*** A search, retrieval, copying and mailing fee may apply.

This document may contain information covered under the Health Insurance Portability and Accountability Act (PL 104-191) and its various implementing regulations, and must be protected in accordance with those provisions. If this correspondence contains protected health information (PHI) it is being provided to you after appropriate authorization from the patient or under circumstances that don't require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized disclosure or failure to maintain confidentiality subjects you to application of appropriate civil and criminal penalties. If you have received this correspondence in error, please notify the sender at once and destroy any copies you have made.