Sebring Clinic

16811 Ranch Road 12
Wimberley, TX 78676
(512) 847-5618

MEDICAL RECORDS RELEASE AUTHORIZATION

Return fax: 512-847-8746

Date Issued:____/_____/_____

Patient Name:_____

Date of Birth: ____/_____/_____

The person named above hereby authorizes Sebring Clinic to ☐ obtain ☐ release the following records

☐ Office Visits
☐ History & Physical
☐ Physical/Occupational Therapy Reports
☐ Emergency Department Reports
☐ Cardiac Reports
☐ Radiology Reports
☐ Laboratory Reports
☐ Operative Reports
☐ Discharge Summary
☐ Other _____
☐ Other _____

The person named above authorizes information to be ☐ requested ☐ released by

Person/Provider /
Facility_____

Address_____

_____

Phone_____-_____-_____

Fax_____-_____-_____

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I understand that the information released may obtain reference to or results of HIV/AIDS testing, and/or alcohol or substance abuse, and/or mental health information.
If requesting Medical Records to be released directly to patient:
I understand that my medical records may contain reports; test results and notes that only a physician can interpret. I will not alter or edit my medical records in anyway. I will not hold Sebring Clinic liable for any misinterpretation of my medical records as a result of consulting a physician for the correct interpretation. I will not hold Sebring Clinic liable should my medical record fall into the hands of any unauthorized individual after it has been consigned in to my custody.

_____ _____/_____/_____
Patient Signature/Legal Representative Date

_____
Relationship to Patient