PATIENT REQUEST FOR MEDICAL RECORDS TRANSFER

PATIENT FULL NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE ____ ZIP _____

SOCIAL SECURITY _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I have been a patient of Angel's Star Wellness Center (or am the patient's authorized representative) and I understand that this practice/facility provider has legally protected health information about me (or the person I represent) that I wish to transfer.

Angel's Star Wellness Center
Dr Chau Pham DO & Dr Jennifer Trinh DO
8325 Whitley Rd, Suite 100
Watauga, TX 76148
P : 817.479.1181 F : 817.918.4432

I hereby authorize Angel's Star Wellness Center to release my records to:

PROVIDER NAME _____

ADDRESS _____ CITY _____ STATE ____ ZIP _____

PHONE NUMBER _____ FAX NUMBER _____

RECORDS TO RELEASE :

▢ LABORATORY ▢ RADIOLOGY AND IMAGING ▢ STRESS TEST / EKG ▢ CONSULTATIONS

▢ CLINIC PROGRESS NOTES ▢ OTHER RECORD FOR : _____

DATES TO RELEASE FROM : _____ TO _____

PURPOSE OF RELEASE : _____

Texas Health & Safety Code Ann. 241.52 (Vernon 2001) requires an authorization for release of medical records to include the reason/purpose for the release.

I or my authorized representative request that health information regarding my care and treatment be released as indicated on this form.
By signing, I understand that I may revoke this authorization in writing but this will not affect any disclosures/transfers already in progress with this authorization. I understand that the requestor may not lawfully further use or disclose the health information unless another Authorization is obtained from me or unless the disclosure is specifically required or permitted by law.

Due to procedural and regulated steps involved with the process of release of information, costs are associated with compiling medical records and, therefore, there could be an associated fee incurred by you for requests for medical records. As directed by the Texas Medical Board (TMB) rules (including §165.2. Medical Record Release and Charges), a fee of $25 for the first 20 pages and 50 cents for each page thereafter may be charged for medical records.

➤ _____ _____
Signature of Patient or Legal Guardian Date