

**Merit Internal Medicine**  
**Authorization to Release Medical Records**

Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone# \_\_\_\_\_

I, the undersigned, authorize the release of, or request access to, the information specified below from the medical record(s) of the above named patient.

PATIENT INFORMATION IS NEEDED FOR MEDICAL TREATMENT

INFORMATION TO BE RELEASED OR ACCESSED SHOULD INCLUDE THE FOLLOWING:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Progress Notes   | <input type="checkbox"/> EKG Tracings        |
| <input type="checkbox"/> Lab/Path Reports   | <input type="checkbox"/> Medication List  | <input type="checkbox"/> Immunization Record |
| <input type="checkbox"/> Radiology Reports  | <input type="checkbox"/> Hospital Records | <input type="checkbox"/> Face Sheet          |
| <input type="checkbox"/> Other              |   |  |

DATE RANGE \_\_\_\_\_ to \_\_\_\_\_

The above information may be released to (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address).

TO: **Merit Internal Medicine**  
Address: **7777 Forest Lane (Suite B-216)**  
Phone: **972-314-9330** Fax: **972-314-9331**

FROM: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.

I understand that the specified information to be released may include, but is not limited to, history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization.

This authorization will expire six (6) months from the date of my signature unless I revoke the authorization prior to that time.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name of Patient or Legally Authorized Representative: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_