



### Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**HIV/AIDS:** I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**The information you may release subject to this signed release form is as follows:**

- Complete Records     History & Physical     Progress Notes     Care Plan
- Lab Reports     Radiology Reports     Pathology Reports     Treatment Record
- Operative Reports     Hospital Reports     Medication Record     Other (please specify below)

\_\_\_\_\_  
\_\_\_\_\_

**Release my protected health information to the following physician/person/facility/entity:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: State: Zip Code: \_\_\_\_\_

**The purpose/reason for this release of information is as follows:  
I understand that NexGen Oncology will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.**

**Signature:**

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Patient Date of Birth or Social Security Number

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority