Office Use Only:		
Faxed To:		
	Individual or Organization Name	
Scanned/Faxed by		Date

Medical Records Release Form

I hereby authorize the use or disclosure of health information from the medical records of:

Patient Name: ________________________________ **Date of Birth:** ______ /______ /______

The reason or purpose for this release of information is for: A New Patient Evaluation

☐ **Yes**, I voluntarily consent to the release of this information.

☐ No, I do not consent to the release of this information.

I, authorize the release of confidential health information about me to **Kerwin Medical Center, LLC** to the following fax number: **(214) 583-2278**.

Specific Description of Information to be release:

☐ Progress Notes (3 most current)

☐ Radiology report(s) (Brain MRI, MRI of head, CT of head, lumbar puncture, etc.)

☐ Neuropsychological report(s)

☐ Diagnostic study reports (labs, etc.)

☐ Other ____________________________________

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. However, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentially rules. I understand that I may revoke this authorization at any time by providing a written consent to Kerwin Medical Center, LLC. I understand that the condition for release is not based on payment for treatment and care, enrollment or eligibility on whether I sign the authorization. **Unless otherwise revoked, this authorization will remain effective from the date signed and will not expire until a written consent has been provided to Kerwin Medical Center, LLC.**

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

___________________________________ ___________________________

Signature of Patient or Legal Representative | Date

____

Relationship to Patient (If Legal Representative)

KERWIN MEDICAL CENTER

Medical Records Release Form

I, authorize the following individual(s) or organization(s) below to release confidential health information about me to **Kerwin Medical Center, LLC**.

PRIMARY CARE / INTERNAL MEDICINE

Individual or Organization	Phone Number	Fax Number
Example: Dr. General	*xxx-xxx-xxxx*	*xxx-xxx-xxxx*

NEUROLOGY

Individual or Organization	Phone Number	Fax Number
Example: Dr. Neuro	*xxx-xxx-xxxx*	*xxx-xxx-xxxx*

OTHER SPECIALTY – PLEASE SPECIFY

Individual/Organization and Specialty	Phone Number	Fax Number
Example: Dr. ABC	*xxx-xxx-xxxx*	*xxx-xxx-xxxx*

Signature of Patient or Legal Representative

Date