Rios Family Medicine Clinic, PA

2222 greenhouse Rd. #1000
Houston, TX 77084
281-944-9095 888-809-8549 (fax)

Request For Release of Records

Patient Name: _____

Previous Name: _____

SSN:_____-_____-_____ DOB:_____/_____/_____

I request and authorize _____
Phone :_____Fax:_____ **to release any and all medical information of the patient name above to:**

Gaddiel D. Rios, MD
2222 Greenhouse Rd. #1000
Houston, TX 77084

This request and authorization applied to any and all medical records and documents, including, but not limited to, progress notes, lab reports, radiological findings, histories, and physical, electrophysiological studies, physical therapy reports, consultation reports, and any and all other medical documents currently in your possession.

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (Aids virus), sexually transmitted diseases, psychiatric disorders/mental health, or drugs and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

I understand that I may revoke/cancel this authorization at any time by giving Gaddiel D Rios office written notice of my decision to do so.

I understand that once my records are sent that they will no longer be within _____ control, and might be re-released by Gaddiel D Rios, MD.

This authorization will expire thirty days from today, after which point it will no longer be valid.

_____ _____
Patient Signature or Representative Date

_____
Relationship if signed by anyone other than patient