ATHENA FAMILY MEDICINE

8301 Lakeview Pkwy, Suite 106, Rowlett, TX 75088 · Phone 469-931-2602 · Fax 469-931-2623

Kevin Vo, MD
Board Certified
Family Medicine

AUTHORIZATION TO RELEASE HEALTH INFORMATION

FROM Athena Family Medicine

Please complete the entire form. I authorize **Athena Family Medicine** (Kevin Vo, MD) to release health records for:

Patient name _____ Date of birth _____ Last 4 of SSN _____

Primary phone _____ Other phone _____

Records to release: ☐ All records ☐ Office visit notes ☐ Lab results ☐ Imaging reports ☐ Immunizations ☐ Billing records ☐ Other: _____

Covering dates from _____ to _____

☐ or all dates

Purpose of release _____

Please release records to:

Name of person, provider or facility _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

☐ Release directly to me (the patient). See page 2.

I understand that the information in my health record may include information about sexually transmitted infections, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug use.

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

Revocation: I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it.

Expiration: Unless I write a different date or event here: _____, this authorization expires 90 days from the date of my signature.

Re-disclosure: I understand that information released under this authorization may be re-disclosed by the person or facility receiving it and may no longer be protected by federal privacy law.

Medical care is not conditional on signing this authorization. The physician and employees are released from legal responsibility or liability for disclosing the above information to the extent indicated and authorized here.

_____ _____ _____

Signature of patient or legal representative | Relationship to patient | Date

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Patient name: _____

Fees

There may be a fee for preparing and providing copies of records: $25.00 for the first 20 pages and $0.50 for each additional page. Copies of billing records: $25.00.

Complete only if records will be released directly to the patient

I understand that my medical records may contain reports, test results and notes that a physician should help interpret. I have been advised to contact my physician with questions about the entries in my record, to avoid misunderstanding the information. I will not hold any staff member responsible for my misinterpretation of my medical record if I do not consult my physician.

Signature of patient or legal representative	Relationship to patient	Date
_____	_____	_____

OFFICE USE ONLY

Date request received _____ Date completed _____

Pages copied _____ Charges $ _____ Completed by _____

Sent by: ☐ Mail ☐ Fax ☐ Picked up ☐ Secure electronic