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

TO Athena Family Medicine

Please complete the entire form.

I authorize (name of doctor or facility that has the records) _____

Their phone _____ Their fax _____

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
☐ Other: _____

Covering dates from _____ to _____

☐ or all dates

Purpose of release _____

For example: continuing care with a new doctor.

Please send records to:
Kevin Vo, MD / Athena Family Medicine
8301 Lakeview Pkwy, Suite 106, Rowlett, TX 75088
Phone 469-931-2602 · Fax 469-931-2623

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