FAMILY MEDICINE AT WILLOW BEND

5944 West Parker Road Suite 100 Plano Texas 75093 Phone: 972-608-1868 **Fax: 972-943-8644**

Jeffrey Komenda, M.D.

STEP

Medical Record Release Authorization

1. *I,* _____ *give permission and authorize Dr.*
(Guardian if a child under 18, or the Patient if an Adult)

Komenda of Family Medicine at Willow Bend to release the medical records of

2. _____ *to themselves and or the following*
(Patient) (DOB)

person, other Doctor's Office, your Insurance Company, your Attorney, or other

3. *entity listed here* _____.

*Phone*_____*Fax*_____
(Receiver of the Medical Records)

I understand that my records cannot be disclosed without my written authorization, except as otherwise provided for by law. I also understand that I may revoke this authorization at any time with written notice, except to the extent that action has already been taken to release records as authorized by this document. I understand that a photocopy or a facsimile of this authorization is as valid as the original.

4.

Type of Records to be released: (Please circle records to be released)

1. **ALL RECORDS**
2. Office Visits
3. Shot Records
4. Labs and X-rays
5. HIV, Drug, or Alcohol related records
6. Other _____

5.

6. Patient or Guardian: _____ _____
(Printed Name) (Signature)

Please complete all 6 steps of this Authorization to expedite the processing of the medical records involved in this transaction. Thank You.

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