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.

Medical Record Release Authorization 1. ,			
1. I,	<u>STEP</u>	Medical Record Release Authorization	
Loss and 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. 1. ALL RECORDS 2. Office Visits 3. Shot Records 4. Labs and X-rays 5. HIV, Drug, or Alcohol related records 6. Other		Medical Necola Neledado / Natitoria de la	
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person, other Doctor's Office, your Insurance Company, your Attorney, or other entity listed here		Komenda of Family Medicine at Willow Bend to release the medical records of	
person, other Doctor's Office, your Insurance Company, your Attorney, or other entity listed here			
Phone	2.	(Patient) (DOB)	
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Bationt or Guardian:	5.		
Patient or Guardian: (Signature)	<i>-</i>		
(Printed Name)	6.	Patient or Guardian: (Signature)	
		(Pfinted Name)	

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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STEP	
SILF	Medical Record Release Authorization
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1.	I, give permission and authorize Dr.
	Komenda of Family Medicine at Willow Bend to release the medical records of
2.	to themselves and or the following
2.	(Patient) (DOB)
	person, other Doctor's Office, your Insurance Company, your Attorney, or other
3.	entity listed here
	PhoneFax
- 39	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.