ELPIS HEALTHCARE

4116 W Spring Creek Pkwy., Unit 400C, Plano, TX 75024 | O: (469) 983-5000 | F: (469) 983-5555

425 Westpark Way, Suite 102, Euless, TX 76040 | O: (817) 354-7070 | F: (817) 354-7073

MEDICAL RECORDS RELEASE

FAX TO: (Plano) 469.983.5555
(Euless) 817.354.7073

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone Number _____

Date of Request _____ **Date Needed** _____

AUTHORIZATION

□ I authorize **Elpis Healthcare**
To **RELEASE** information to:

Name of provider or facility

Address

City State Zip

Phone Number

□ I authorize **Elpis Healthcare**
To **OBTAIN** information from:

Name of provider or facility

Address

City State Zip

Phone Number

PURPOSE FOR THIS REQUEST (CHECK ONE BOX ONLY)

□ Healthcare □ Insurance Coverage □ Legal □ Personal □ Other

TYPE OF RECORDS REQUESTED (CHECK ONE BOX ONLY)

□ Progress Notes □Diagnostic Reports □ Operative Repots

□ Entire Copy of My Record □ Other (describe):

AUTORIZATION VALID FOR (CHECK ONE BOX ONLY)

□ This request only □ One year from the date of the authorization

STATEMENT TO RELEASE PROTECTED HEALTH INFROMATION

I understand that:

- My right to health car e treatment is not conditioned on the authorization.
- I may cancel this authorization at any time by submitting a written request to Texwell Health, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations. The information stated above could be redisclosed.
- Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may b e charged for the requested records not to exceed $25.00.

Signature of patient or representative: _____ Date: _____

_____

Relationship to patient (if requester is not the patient)

FOR INTERNAL USE ONLY

DATE RECEIVED: DATE PRCCESSED: INITIALS: