



# PRIME VITAL CLINIC

## MEDICAL RECORDS RELEASE AUTHORIZATION FORM

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Release Records From:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Release Records To:** **Prime Vital Clinic**  
Dr. Clara Ike  
2017 N Frazier St Suite G8A, Conroe, TX 77301  
Phone: (936) 703-3468 Fax: (936) 703-3469

The health information you may release subject to this authorization is as follows (✓):

\_\_\_\_ All medical records    \_\_\_\_ Labs    \_\_\_\_ Radiology    \_\_\_\_ Consult Notes  
\_\_\_\_ From service date(s): \_\_\_\_\_ to \_\_\_\_\_

**HIV/AIDS:** I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agents of AIDS with the rest of my medical records. **Initial:** \_\_\_\_\_ **Date:** \_\_\_\_\_

The purpose for this release of information is for patient care and treatment. This authorization shall be in force and effective for 60 DAYS from the date below. By signing this form, I authorize you to use and disclose the protected health information. I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to Prime Vital Clinic at the address below. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date