



Prime Vital Clinic
Medical Records Release Form

Date _____

Patient Information:

Name _____

Sex ☐ M ☐ F DOB _____ Last 4 SS# _____

This form is for use when such authorization is required and complies with HIPAA Privacy Standards.

I, _____ hereby voluntarily authorize the
(Name of Patient)

disclosure of information from my health records. I understand this includes copies of
medical records, laboratory results, radiology results, and/or summary included in my health records.

- ☐ Entire Medical Record
☐ Medical Records for specific date(s) of service From/To: _____
☐ Laboratory results
☐ Only the following specific information: _____

Information Requested:

Doctor's Office Name: _____

Phone Number: _____

Fax/Email: _____

Address: _____

City/State/Zip: _____

Release Medical Records to:

Prime Vital Clinic
2017 N Frazier G-8A
Conroe Texas 77301

Phone: _____

Fax: _____

Email: _____

The authorization for the release of my medical records is being issued at my request.

I have read and understand this form and I am signing it voluntarily. I authorize the disclosure
of my Health Information as described in this form.

Patient or Authorized Signature

☐ Self ☐ Parent
☐ Other _____

Witness Signature

Date: _____