



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: Fax:

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