

# Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

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

**Limitations on the information you may release subject to this Release Form are as follows:**

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**Release my protected health information to the following person(s)/entity:**

Name: CHARLES B. MALLETT, MD

Street: 4007 JAMES CASEY STREET SUITE A200

City: AUSTIN State: TEXAS Zip: 78745

**The reasons or purposes for this release of information are as follows:**

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\_\_\_\_\_  
**Patient Signature [or parent, guardian or legal representative]:**

\_\_\_\_\_  
**Patient Name [or parent, guardian or legal representative]:**

Date: \_\_\_\_\_

**I understand that you will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.**