Baptist
Physician Network
Affiliated with Baptist Hospitals of Southeast Texas
Performing Sacred Work Everyday

MEDICAL RECORD RELEASE FORM

By signing this form, I authorize _____ 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 results 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:

Release my Protected Health Information to the following person(s)/entity:

Name: **Baptist Physician Network Heart & Vascular Clinic**

Address: **740 Hospital Drive, Suite 260**

City: **Beaumont** **State: Texas** **Zip: 77701**

Phone: **409-212-7860** **Fax: 409-835-7005**

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

Print Patient Name: _____
Last First Initial

Date of Birth: _____-_____-_____ Social Security#: _____-_____-_____

Patient Signature (Or Parent, Guardian or Legal Representative):

_____

Date: _____

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